ABE International Membership

Today's Date: _____

Name: _____Professional Credentials: _____

Institution or Practice Name:_____

Preferred Address (please check one): ☐ Work ☐ Home

Number/Street:_____

City, State Zip Code:_____Country:_____

Preferred Email Address:_____

Alternate Contact Address ☐ Work ☐ Home

Number/Street:_____

City, State Zip Code:_____Country:_____

Education:

	Institution Name	Beginning Year	End Year	Program Director's Name
Residency:				
Fellowship:				

Board Certification:

Internal Medicine Certification: _____Expiration date: _____

Specialty Board Certification:_____Expiration date: _____

Surgical Board Certification:_____Expiration date: _____

Licensure State: _____Country: _____Registry Number: _____

*__Please list the name of an ABE member who will sponsor your application.__

Name: _____Email:_____

Practice/Professional Information

Procedure:	Balloon Placement	ESG	Gastric Banding	Gastric Bypass	Other
# last 12 months					

Practice Environment (please check applicable):

☐ Solo Practice ☐ Hospital ☐ Government/VA Hospital ☐ University based group
☐ GI group practice ☐ Bariatric Center ☐ Other _____

Demographic Information (optional – for statistical purposes only; please choose *any* with which you identify):
Race:

☐ American Indian
☐ Black (Caribbean)
☐ Black (African)
☐ Native Alaskan
☐ Pacific Islander
☐ Other

☐ Asian
☐ Black (American)
☐ Caucasian/White
☐ Native Hawaiian
☐ Multiracial
☐ Prefer not to answer

☐ Hispanic/Latino (specify):
☐ American
☐ South American
☐ Caribbean
☐ Central American
☐ European

Do you consider yourself:

☐ Female ☐ Male ☐ Transgender ☐ Prefer not to answer

Date of Birth _____ (MM/DD/YYYY)

Reasons for Joining ABE (please check all that apply):

☐ Education ☐ Professionalism ☐ SmartBrief ☐ Course Discounts ☐ Advocacy/Legislation

Payment: US Dollars

ABE Membership Dues (includes membership in ASGE): $485 USD

Form of Payment (please check one):
☐ **Check #_____**

☐ **AX** ☐ **VI** ☐ **MC** ☐ **DS** **Total Authorization: $_____**

Credit Card Number: _____Expiration Date (mm/yy): ____/____

Name as it appears on Card: _____

Application fees for incomplete applications become non-refundable after 45 days.

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Submit completed application via email:

rlarosa@asge.org
OR
Fax to 630.963.8607
Attn: Membership

SUBMIT

To submit via postal service:

Association for Bariatric Endoscopy
3300 Woodcreek Drive
Downers Grove, IL 60515

By completing and submitting this application, you attest that the information provided is true and accurate.