



Association for
Bariatric Endoscopy

ABE International Membership/SAGES Members



Today's Date: _____

SAGES Member ID# (if known) _____

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:

Surgical Board Certification: _____ Expiration date: _____

Board Certification (other): _____ Expiration date: _____

Licensure State: _____ Country: _____ Registry Number: _____

***If you are not Board certified, please list the name of an ABE member who will sponsor you.**

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:

- | | | |
|--------------------------------------------|-----------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic/Latino (specify): |
| <input type="checkbox"/> Black (Caribbean) | <input type="checkbox"/> Black (American) | <input type="checkbox"/> American |
| <input type="checkbox"/> Black (African) | <input type="checkbox"/> Caucasian/White | <input type="checkbox"/> South American |
| <input type="checkbox"/> Native Alaskan | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Caribbean |
| <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Multiracial | <input type="checkbox"/> Central American |
| <input type="checkbox"/> Other | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> 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 ☐ Newsletter ☐ Webinars ☐ 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.

Submit completed application via
email:

asaylor@asge.org

OR

Fax to 630.963.8607

Attn: Membership

To submit via postal service:

Association for Bariatric Endoscopy

A Division of 

3300 Woodcreek Drive

Downers Grove, IL 60515

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