# ABE Active 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:**

ABIM # (if applicable):_____NPI # (if applicable):_____

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:

☐ 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): $545 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:**

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

SUBMIT

**To submit via postal service:**

**Association for Bariatric Endoscopy**
**A Division of ASGE**
**3300 Woodcreek Drive**
**Downers Grove, IL 60515**

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