



ABE Trainee 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:

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

Licensure State: _____ Country: _____ Registry Number: _____

***Please provide the name and email address of your GI program director for endorsement:**

Name: _____ Email: _____

Practice/Professional Information (in training):

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

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 SmartBrief Course Discounts Advocacy/Legislation

Payment: US Dollars

ABE Membership Dues (includes membership in ASGE through end of training; you will be billed \$25 for ABE membership annually):

**First Year Fellows: \$75 USD
Second Year Fellows: \$50 USD**

**Third Year Fellows: \$25 USD
Fourth Year/Advanced Fellows: \$25 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

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.