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	☐ Asian	☐ Hispanic/Latino (specify):
☐ Black (Caribbean)	☐ Black (American)	☐ American
☐ Black (African)	☐ Caucasian/White	☐ South American
☐ Native Alaskan	☐ Native Hawaiian	☐ Caribbean
☐ Pacific Islander	☐ Multiracial	☐ Central American
☐ Other	☐ Prefer not to answer	☐ 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:

info@bariendo.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.