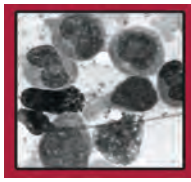

ASBMT™
American Society for Blood and Marrow Transplantation

Membership Application & Eligibility Requirements

Checklist for submitting ASBMT membership application:

- ☐ Check the membership category for which you are applying.
- ☐ Complete the application.
- ☐ Sign and date the application.
- ☐ Enclose curriculum vitae.
- ☐ Enclose letter of reference from training program director (including start and end dates), if applying for In-Training Member category.
- ☐ Enclose dues payment with application.
- ☐ Return completed application and enclosures to the address below.

American Society for Blood and Marrow Transplantation

85 W. Algonquin Road, Suite 550
Arlington Heights, IL 60005
(847) 427-0224 • Fax: (847) 427-9656
Email: membership@asbmt.org
www.asbmt.org

Membership Requirements.

For membership eligibility in the American Society for Blood and Marrow Transplantation, an applicant must meet the following requirements:

Member. To qualify as a Member, the applicant must:

1. Hold an MD or PhD degree with demonstrated expertise in blood and marrow transplantation as evidenced by *either*
   - **a.** the publication of two papers on blood and marrow transplantation or cellular therapy-related research as recorded by curriculum vitae, *or*
   - **b.** documentation of two years of experience in clinical transplantation as recorded by curriculum vitae or letter from the director of a transplant center attesting to the experience of the candidate.
2. Be of high moral, ethical and professional standing.

Associate Member. To qualify as an Associate Member, the applicant must hold an MD or PhD degree but not otherwise meet the criteria for full membership.

In-Training Member. To qualify as an In-Training Member, the applicant must be one of the following *(check one):*

- ☐ A post-doctoral fellow with an interest in Bone Marrow Transplantation or Hematology/Oncology
- ☐ A Fellow-In-Training in a Bone Marrow Transplantation or Hematology/Oncology program
- ☐ Enrolled in a Nurse Practitioner (NP), Physician Assistant (PA), Nursing (RN), or PharmD training program.

Affiliate Member. To qualify as an Affiliate Member, the applicant can be an allied non-MD or non-PhD professional with an interest in cellular therapy or blood and marrow transplantation. Affiliate membership is especially appropriate for nursing and administrative staff of bone marrow transplant centers, collection centers and processing laboratories, and for professional staff of health care corporations in the field of blood and marrow transplantation.

Application Procedure.

Individuals seeking ASBMT membership, or seeking to move from one membership category to another, shall apply in writing on a Membership Application form. In-Training Members are automatically graduated to full Member status after training ends.

Upon receipt of an application form, the ASBMT Membership Committee will evaluate the applicant's qualifications and report its findings to the Executive Committee of the Board of Directors.

An applicant meeting the qualifications of a membership category shall be elected to that category upon affirmative vote by the members of the Board of Directors or its Executive Committee at a duly called and convened meeting. Final determination of the acceptability of an application and the applicant's documentation shall be with the Board of Directors.

Dues. Annual dues for membership categories are: Member $225, Associate Member $225, Affiliate Member $150, In-Training Member (non US- or Canada-based) $75, In-Training Member (US- or Canada-based) FREE.

Application Fee. Payment of dues for the calendar year must accompany the Membership Application. The dues will be refunded if the application is not accepted.

Membership Application
American Society for Blood and Marrow Transplantation

I am applying for:

- ☐ Member ($225)
- ☐ Associate Member ($225)
- ☐ Affiliate Member ($150)
- ☐ In-Training Member (US- or Canada-based: Free)
- ☐ In-Training Member (International: $75)

PLEASE PRINT OR TYPE:

First Name: _____ Middle Name: _____

Last Name _____ ☐ MD ☐ PhD ☐ RN ☐ PharmD ☐ Other: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Institution or Company: _____

Title: _____

Primary Office Address: _____

_____

City: _____ State/Province: _____ Zip/Mailing Code: _____ Country: _____

Work Phone: _____ Fax: _____

Please provide both email addresses: *(PRINT CAREFULLY)*:

Professional/Work Email: _____

Personal/Home Email: _____

While your home address and phone number will be retained on file, they will NOT be published, unless your home is your primary mailing address.

Home Address: _____

_____

City: _____ State/Province: _____ Zip/Mailing Code: _____ Country: _____

Home Phone: _____ Cell Phone: _____

I wish to have my mail sent to *(CHECK ONE)*: ☐ Office Address ☐ Home Address

Education and Training

Degrees	***Name of University (Undergraduate)***	***City, State & Country Location***	***Year Completed***
_____	_____	_____	_____
_____	_____	_____	_____

For Office Use Only:

Institution: _____ Type of Residency/Fellowship (if applicable): _____

Program Director's Name: _____ Start Date (mm/dd/yy): _____ End Date (mm/dd/yy) _____

☐ Still in Training

…CONTINUED ON NEXT PAGE

Name of Medical or Graduate School

Degrees	*Name of University (Undergraduate)*	*City, State & Country Location*	*Year Completed*

Name of Hem/Onc or BMT Training Program

Did you complete BMT training in addition to a standard Hem/Onc Fellowship? . . . . . ☐ Yes ☐ No

Was your BMT training a full year? . . . . . ☐ Yes ☐ No

BMT Specialization: Are you Board Certified in? *(check as many as apply)*

☐ Internal Medicine ☐ Oncology ☐ Hem/Onc
☐ Pediatrics ☐ Hematology ☐ Other: _____

How would you classify your status as a BMT Physician? *(check one)*

☐ Primarily Pediatric BMT ☐ Primarily Adult BMT ☐ Both Pediatric and Adult BMT

Do you live and practice in the United States? . . . . . ☐ Yes ☐ No

If you are a physician, do you practice as a clinical transplant physician for at least 20% of your time? . . . . ☐ Yes ☐ No

If you are a physician, please check the clinical specialties or subspecialties that apply to you:

☐ Genetics ☐ Immunology ☐ Microbiology ☐ Pediatrics
☐ Hematology ☐ Internal Medicine ☐ Oncology ☐ Other: _____

If you are primarily in research, please check the areas of major interest:

☐ Cancer cell biology ☐ Hematopoiesis ☐ Immunology/ immunotherapy ☐ Molecular oncology/ gene therapy
☐ Chemotherapy/ pharmacology ☐ Histocompatibility ☐ Microbiology ☐ Other: _____

Required:

Have you been the subject of any disciplinary action by a local or state medical society or medical licensing body within the past 10 years? . . . . . ☐ Yes ☐ No ☐ N/A

If yes, please provide an explanation on an accompanying page.

Have you had your hospital privileges suspended, revoked or modified within the past 5 years? . . ☐ Yes ☐ No ☐ N/A

Demographic

Primary Employment Settings:

☐ Government Hospital/Clinic
☐ Medical School/University
☐ Non-Government Hospital/Clinic
☐ Pediatric/Multispecialty Group Practice
☐ Solo/Two Physician Practice
☐ Staff Model HMO
☐ Other: _____

Primary Practice/Position Area:

☐ Military
☐ Rural
☐ Suburban
☐ Urban, inner city
☐ Urban, non-inner city
☐ Other: _____

Size of Institute:

☐ Fewer than 99 Beds
☐ 100-199 Beds
☐ 200-299 Beds
☐ 300-399 Beds
☐ 400+ Beds
☐ Not Applicable

…CONTINUED ON NEXT PAGE

Please indicate the percentage of your time spent in each of the following areas: *(Numbers should total 100.)*

_____% Clinical Practice
_____% Clinical Research
_____% Administration
_____% Laboratory Research
_____% Teaching
_____% Supervising Apheresis/Cell processing
_____% Other _____

100 %

Ethnic / Culture Group:

☐ African American/Black ☐ Hispanic ☐ White/Non-Hispanic
☐ Asian/Pacific Islander ☐ Native American/Native Alaskan ☐ Other _____

Special Interest Groups

ASBMT has seven special interest groups (SIGs). There is no additional cost for joining a SIG. Check those that you would like to join:

☐ Administrative Directors ☐ NPs and PAs ☐ Pharmacy
☐ Cord Blood ☐ Nursing ☐ Transplant Infectious Diseases
☐ HCT Survivorship ☐ Palliative Care
☐ HCT Value and Health Economics ☐ Pediatric

Privacy Statement: ASBMT periodically rents its membership lists to organizations that wish to promote educational courses, publications and other products or services that are of interest to the BMT community.

If you wish to be excluded, please check here: ☐

By signing below, you give consent to receive faxes, emails and mailings sent by ASBMT.

_____
Signature

Certification

I hereby certify that all information recorded on this application and any attached documents is accurate and supports my qualifications for membership in ASBMT to which I now apply.

Signature: _____ Date:_____

Dues Payment

Payment is accepted via check drawn on a U.S. bank, Visa, MasterCard or American Express.

☐ Check enclosed ☐ Visa ☐ MasterCard ☐ American Express

Card Number: _____

CSV Code:_____ Expiration Date: _____

Promo Code_____ **Signature:** _____

Please remit dues with application form. An incomplete or unsigned application will be returned.

RETURN TO:

American Society for Blood and Marrow Transplantation
85 W. Algonquin Road, Suite 550 • Arlington Heights, IL 60005
(847) 427-0224 • Fax: (847) 427-9656 • Email: membership@asbmt.org

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