



# 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:

- |  |   |   |
|--|---|---|
| <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): \$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@bariando.org](mailto:info@bariando.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.***