

ASSOCIATION OF BLACK CARDIOLOGISTS, INC.

5355 Hunter Road Atlanta, GA 30349
 Phone: 404-201-6600 Fax: 404-201-6601
 www.abccardio.org



Professional Membership Application

COMPLETE ALL FIELDS. A RESUME AND PHOTO ARE REQUIRED TO COMPLETE APPLICATION PROCESS (PLEASE PRINT)

Date of Application: _____ Date of Birth: _____ Are you a Clinician? Yes No

<p>SPECIALTY _____</p> <p>If Cardiology (check one)</p> <p><input type="checkbox"/> Interventional <input type="checkbox"/> Invasive <input type="checkbox"/> Noninvasive <input type="checkbox"/> Pediatric</p> <p><input type="checkbox"/> Adult Cardiology <input type="checkbox"/> Electrophysiology <input type="checkbox"/> Nuclear <input type="checkbox"/> Surgery</p>	<p>RACE/ETHNIC BACKGROUND (OPTIONAL)</p> <p>Please check one of the following:</p> <p><input type="checkbox"/> African American <input type="checkbox"/> Asian/Indian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> Other _____ <input type="checkbox"/> Male <input type="checkbox"/> Female</p>
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NAME / DEMOGRAPHIC DATA

Last Name _____ First Name _____ Middle Initial _____ Degrees _____

Institution Affiliation _____ Academic Title _____

Office Contact Name and Number _____

Office Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

PREFERRED MAILING ADDRESS Work Home PREFERRED EMAIL Work Home Do not list in Online Directory

EDUCATION

Medical School Attended _____ Year of Graduation _____

Internal Medicine Training _____ Year of Completion _____

Cardiology Training Program _____ Year of Completion _____

Board Certification: (1) _____ Year: _____ (2) _____ Year _____

Board Eligibility: (1) _____ Year: _____ (2) _____ Year _____

Practice Type: Group Hospital Private Academic Other _____

MEMBERSHIP CATEGORIES	LIFE MEMBERSHIP
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<p><input type="checkbox"/> FULL MEMBERSHIP.....\$350.00</p> <p><input type="checkbox"/> ASSOCIATE MEMBERSHIP.....\$175.00</p> <p><input type="checkbox"/> CLINICAL CARE ASSOCIATE.....\$125.00</p> <p><input type="checkbox"/> CARDIOLOGY FELLOWS.....\$ 88.00</p> <p><input type="checkbox"/> EMERITUS (RETIRED).....\$ 50.00</p> <p><input type="checkbox"/> MEDICAL STUDENTS.....\$ 50.00</p> <p><input type="checkbox"/> INSTITUTIONAL MEMBERSHIP.....\$1,000.00</p>	<p><input type="checkbox"/> LIFE MEMBERSHIP (Payable in 3 years)..... \$5,250.00</p> <p>_____ \$5,250</p> <p>_____ \$1,750** (1st installment)</p> <p>\$_____ Total enclosed (including dues)</p> <p>**Please note membership dues will continue to be payable until Life Member status is reached.</p>
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METHOD OF PAYMENT FOR MEMBERSHIP AND/OR DONATION

<p><i>Checks Payable To:</i> Association of Black Cardiologists, Inc.</p> <p><input type="checkbox"/> Check (drawn on US Bank in US Dollars) ___ Business ___ Personal ___ Institution Check# _____</p> <p><input type="checkbox"/> Credit Card ___ MasterCard ___ Visa ___ American Express</p> <p>Card Number _____ Expiration date _____</p> <p>Name as it appears on card _____</p> <p>Signature _____</p>	<p><i>For Tax-deductible Donations</i></p> <p>AMOUNT \$ _____</p> <p><input type="checkbox"/> ANNUALLY <input type="checkbox"/> QUARTERLY</p> <p><input type="checkbox"/> MONTHLY <input type="checkbox"/> ONE TIME GIFT</p>
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