ASSOCIATION OF BLACK CARDIOLOGISTS, INC.
122 East 42nd Street, 18th Floor
New York, NY 10168
Phone: 800-753-9222
www.abcardio.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

SPECIALTY ____

If Cardiology (check one)

□ Interventional □ Invasive □ Noninvasive □ Pediatric
□ Adult Cardiology □ Electrophysiology □ Nuclear □ Surgery

RACE/ETHNIC BACKGROUND (OPTIONAL)

Please check one of the following:

□ African American □ Asian/Indian □ Caucasian □ Hispanic
□ Other _________________________ □ Male □ Female

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

□ FULL MEMBERSHIP..$ 350.00
□ CLINICAL CARE ASSOCIATE $125.00
□ CARDIOLOGISTS-IN-TRAINING (CIT) ....$ 88.00
□ EMERITUS (RETIRED)..$ 50.00
□ MEDICAL STUDENTS, RESIDENTS, INTERNS, FELLOWS (non CV).............. $ 50.00
□ SUPPORTING ORGANIZATIONS.................... ....$ 1,000.00
□ HOSPITAL AND HEALTH SYSYTEMS...$ 2,500.00

LIFE MEMBERSHIP

□ LIFE MEMBERSHIP (Payable in 3 years).......... $5,250.00

__________ $5,250

__________ $1,750** (1st installment)

$_________ Total enclosed (including dues)

**Please note membership dues will continue to be payable until Life Member status is reached.

METHOD OF PAYMENT FOR MEMBERSHIP AND/OR DONATION

Checks Payable To: Association of Black Cardiologists, Inc.

□ Check (drawn on US Bank in US Dollars) ___ Business ____ Personal ____ Institution Check# __________

□ Credit Card ____ MasterCard ____Visa ____ American Express

Card Number ____ Expiration date ______________CVV Code ______

Name as it appears on card ____

Signature ____

For Tax-deductible Donations

AMOUNT $________________

□ ANNUALLY □ QUARTERLY

□ MONTHLY □ ONE TIME GIFT