

ASSOCIATION OF BLACK CARDIOLOGISTS, INC.
 2400 N Street, NW, Suite 604
 Washington, DC 20034
 Phone: 202-375-6618 Fax: 202-375-6801



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

Web: 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>
--	---

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 <input type="checkbox"/> Work <input type="checkbox"/> Home PREFERRED EMAIL <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> 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: <input type="checkbox"/> Group <input type="checkbox"/> Hospital <input type="checkbox"/> Private <input type="checkbox"/> Academic <input type="checkbox"/> Other _____	

MEMBERSHIP CATEGORIES	LIFE MEMBERSHIP
<input type="checkbox"/> FULL MEMBERSHIP\$ 350.00 <input type="checkbox"/> CLINICAL CARE ASSOCIATES\$ 125.00 <input type="checkbox"/> CARDIOLOGISTS IN TRAINING (CIT)\$ 88.00 <input type="checkbox"/> MEDICAL STUDENTS, RESIDENTS, INTERNS, AND FELLOWS (non CV)\$ 50.00 <input type="checkbox"/> HOSPITAL AND HEALTH SYSTEMS\$2,500.00 <input type="checkbox"/> SUPPORTING ORGANIZATIONS\$1,000.00 <input type="checkbox"/> EMERITUS MEMBER\$ 50.00	<input type="checkbox"/> LIFE MEMBERSHIP (Payable in 3 years)..... \$5,250.00 _____ \$5,250 _____ \$1,750** (1 st installment) \$_____ Total enclosed (including dues) <small>**Please note membership dues will continue to be payable until Life Member status is reached.</small>

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