



**AMERICAN ASSOCIATION
FOR BRONCHOLOGY**

Membership Form



**WORLD ASSOCIATION
FOR BRONCHOLOGY**

We respect your right to privacy.

Upcoming enhancements to the AAB website will include secure, member-only access to our membership roster. Please place a checkmark in the box below if you do not wish to have your member information (name, address, contact info) included on the website.

- DO NOT include my name, address, contact information in the AAB website membership roster.**

Occasionally we receive requests for our membership roster from meeting planners or industry-related corporations. The Executive Committee reviews all requests for appropriateness. Please place a checkmark in the box below if you do not wish to have your member information released for mailing list requests.

- DO NOT release my name, address, or contact information to any individual, institution, or corporation requesting the AAB mailing list.**

Other Professional Memberships (check all that apply)

- (A) Japan Society for Bronchology
- (B) American College of Chest Physicians
- (C) American Thoracic Society
- (D) American College of Physicians
- (E) European Respiratory Society
- (F) Asociación Sudamericana de Broncología
- (H) Asociación Española de Endoscopia Respiratoria
- (I) Other _____

Principal Areas of Interest & Expertise (check only three)

- (J) Interventional Bronchoscopy
- (K) Pleural diseases and Thoracoscopy
- (L) Lung Cancer Staging and Detection
- (M) Ultrasonography
- (N) Laser Tissue Interactions and Laser Physics
- (O) Medical and Patient Education
- (P) Virtual Reality and Computer Simulation
- (Q) Database Design and Analysis
- (R) Ethics and End of Life Issues
- (S) Medical Economics
- (T) Evidence-Based medicine and Outcome Analysis
- (U) Health Care Technology Assessment
- (V) Other _____

Updated Member Information (please print).

Date _____

First Name _____ Last Name _____ Degree _____

Institution, organization or company _____

Specialty _____

Address _____ Suite _____

City _____ State _____ Zip Code _____ Country _____

E-mail address _____

Daytime Phone _____ Ext. _____

Daytime Fax Number _____

Membership Type (choose one below).

NEW MEMBER RENEWAL

- AAB-WAB Dual \$200.00
- AAB only \$150.00
- WAB only \$150.00
- AAB Affiliate \$80.00
(non-physician healthcare professional)
- AAB Trainee \$80.00
(a trainee verification letter from your supervisor is required with this form)

Method of Payment

- Visa Mastercard Check (enclosed)

Account Number _____

Name on Card _____ Exp. Date _____

Cardholder Signature _____

**Checks should be made payable to American Association for Bronchology.
Mail or fax this form (and verification letter if warranted) to:
American Association for Bronchology
The Cleveland Clinic Foundation
9500 Euclid Avenue/A90
Cleveland, OH 44195 USA
Fax: 216/636-3137**