SOCIETY OF BEHAVIORAL MEDICINE

Affiliate Membership Application

Organization Information

Organization name (spell out acronyms): _____

City: _____ State/province: _____ Zip/postal code _____ Country: _____

Phone: _____ Fax: _____

Website: _____

Primary Contact

Provide information for the person SBM should contact about all affiliate membership matters.

First name: _____ M.I.: ____ Last name: _____

Degrees: _____ Job title: _____

Phone: _____ Email: _____

Affiliate Membership Level

Check the box for only one level. Benefits vary according to level. For more information on benefits, visit www.sbm.org/membership/affiliate-membership.

All affiliate members receive:

- Ability to post on the SBMConnect blog and in the SBM weekly members-only newsletter.
- Name and logo placement on the SBM website.
- Access to SBM expert consultants.
- Ability to partner with SBM's Health Policy Committee to co-sponsor or co-author health policy briefs.

Additional benefits depend on membership level.

	Complimentary SBM Memberships (These individuals will be able to register for SBM's Annual Meeting at the reduced SBM member rate. They will also have access to journals and special interest group emails.)	Discounted Annual Meeting Exhibit Space	Discounted Mailing List Use	Discounted Rates for Job Ads
☐ Level 1 -- $2,000	2 memberships	10% discount	10% discount	10% discount
☐ Level 2 -- $3,000	3 memberships	15% discount	15% discount	15% discount
☐ Level 3 -- $5,000	5 memberships	20% discount	20% discount	20% discount

List complimentary SBM membership recipients from your organization. List two to five individuals, depending on the affiliate membership level you have selected.

1.
First name: _____ M.I.: ____ Last name: _____
Degrees: _____ Job title: _____
Phone: _____ Email: _____

2.
First name: _____ M.I.: ____ Last name: _____
Degrees: _____ Job title: _____
Phone: _____ Email: _____

3.
First name: _____ M.I.: ____ Last name: _____
Degrees: _____ Job title: _____
Phone: _____ Email: _____

4.
First name: _____ M.I.: ____ Last name: _____
Degrees: _____ Job title: _____
Phone: _____ Email: _____

5.
First name: _____ M.I.: ____ Last name: _____
Degrees: _____ Job title: _____
Phone: _____ Email: _____

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Payment Options

Credit Card:

☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

Credit card #: _____

Expiration date: _____

Name on card: _____

Cardholder signature: _____

Check:

☐ Personal check ☐ Institutional check

Check #: _____

Make checks payable to SBM in U.S. currency only.

You are welcome to charge membership dues payments to your credit card; such charges result in fees charged to SBM (more than $10,000 annually) whereas payments by check do not.

Application Submission

Submit your application by:

Postal Mail:
Society of Behavioral Medicine
555 East Wells Street, Suite 1100
Milwaukee, WI 53202

** Applications are subject to SBM approval.*

Fax:
(414) 276-3349

Email:
info@sbm.org