

American Burn Association
Membership Application
Institutional Member



Please complete this form and mail or fax with payment of your annual membership dues to the American Burn Association, 625 N Michigan, Suite 2550, Chicago, IL 60611
Tel: (312) 642-9260 Fax: (312) 642-9130

Thank you and we look forward to welcoming your institution to membership in the ABA.

Organization Information

Organization _____

Street _____

City/State/ZIP Code _____

Phone & FAX _____

Web site _____

Institutional Advisory Representative

Please list below the individual who will serve as the representative from your institution to the Institutional Advisory Council. The contact person may be either a physician or administrative/executive staff at your institution.

Name _____

Position _____

Phone & FAX _____
(if different than above)

Email _____

Dues

Annual dues are \$4,000 and cover 12 months from date of payment.

- My check, payable to the American Burn Association, is enclosed
- Please charge my credit card: VISA Mastercard American Express

Account Number _____ Expiration date _____

Cardholder's Signature _____

This organization makes application for Institutional Membership in the American Burn Association by submitting the information on this form.

Applicant's Signature & Date _____