



Blood Banks Association of New York State, Inc.

2012 New Member Application

*First Name: _____ Informal (Nickname): _____

*Last Name: _____ *Institution: _____

Designations: _____ Title: _____

***Work Address:**

Home Address:

*Street: _____ Street: _____

P.O. Box: _____ P.O. Box: _____

*City: _____ City: _____

*State: _____ State: _____

*Zip+4: _____ Zip+4: _____

*Phone: _____ Phone: _____

*E-mail: _____ E-mail: _____

***Membership Directory:** Include me with my **institutional** address my **home** mailing address exclude me

***Preferred MAILING ADDRESS:** Work Home ***Preferred E-MAIL ADDRESS:** Work Home

What is your principle specialty? (Example: Apheresis, Processing, Quality Control, etc) _____

Memberships (Check One)	Professional/ Technical	Physician/ Doctorate	Student	Institutional
One-Year:	<input type="checkbox"/> \$30	<input type="checkbox"/> \$50	<input type="checkbox"/> \$10	<input type="checkbox"/> \$75
Three-Year:	<input type="checkbox"/> \$80	<input type="checkbox"/> \$125	N/A	<input type="checkbox"/> \$200

Membership Payment Options:

Check # _____	Payable to: <u>“BBANYS, Inc.”</u>	
	Mail to: <u>BBANYS Membership, 2901 Richmond Road, Suite 130-171, Lexington, KY 40509</u>	
Credit Card <input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> AMEX	Name : _____ (As name appears on credit card)	Card #: _____
	Billing Address of Card Holder: _____ _____	CVC #: _____ (3-4 digits on back of card)
		Exp. Date: _____
		Signature: _____ (Authorizes credit card charge)
Visit www.bbanys.org for more information ● FAX: 888-734-8886 ● PH: 866-397-8883		

* = Required