

Membership Renewal /Registration Form

Last Name*: _____ First Name*: _____ Mr. Ms.

Affiliation*: _____

Affiliation Type*: _____

Professional Title*: _____

Primary Job Function*: _____

Highest Degree*: _____

Street Address*: _____

City*: _____ State*: _____ Country*: _____ Zip*: _____

Tel *: _____

Fax : _____

Primary Email*: _____

Alternative Email*: _____

*Note: * is a required field.*

<u>Classification of Registrant</u>	<u>Fee</u>	<u>Classification of Registrant</u>	<u>Fee</u>
<input type="checkbox"/> New Member/Membership Renewal.....	\$30	<input type="checkbox"/> Lifetime Member.....	\$300
<input type="checkbox"/> Student & Post-Doc.....	\$15		

Please make your check payable to **CABS** (U.S. Currency ONLY, check to be drawn on an U.S. bank), and then return the completed form and the check in an envelope labeled with “Membership” to:

CABS
268 Bush Street, #1888
San Francisco, CA 94104, USA