



ACBIS ALLIANCE MEMBERSHIP APPLICATION

Contact Person Submitting Application:

Name: _____ Title: _____

Organization: _____

Check one: Building or Facility Level Application Total Organization Application

Address: _____

City: _____ State: _____ Zip: _____

Country: _____ Email: _____ Phone: _____

Organization's CEO:

Name: _____

Eligibility Verification:

Attach an Excel spread sheet or other document listing all staff eligible for CBIS or CBIST certification at the level (building, facility, or total organization) applying as of the date of the application. See <http://www.biausa.org/professionals/acbis/acbis-alliance> for eligibility criteria and data fields required.

Confirm file attached Total # Staff: _____ # Certified: _____ % Certified: _____

I certify that the information on this application and on the attached employee roster is true and accurate.

Signature: _____ Date: _____

Please make check for \$1,000.00 payable to **Brain Injury Association of America** and send your check, this form, and the required attachment to **BIAA/ACBIS, P. O. Box 7416, Merrifield, VA 22116-7416**.

Additional plaques (Organization Level Application) are available at \$100 each.

Number of additional plaques (one is included with membership) requested: _____

Total additional amount included in check: _____

To pay by credit card, click here: <https://shop.biausa.org/product/ACBISALLIANCE/acbis-alliance-application>.

You may email this form and the required attachment to acbis@biausa.org.