# MEMBERSHIP APPLICATION

Last Name__________________________First Name _____________________________

M.D. Ph.D. Other *(specify)* ___________

Date of Birth_____/_____/_________ Sex: Male Female

Institution _________________________________________________________

Primary Office Address _____________________________________________________

City______________________________________Postal Code _______________

Country ______________________________

Phone (_______)___________________Fax (_______) ___________________

E-mail ___________________________________

Home Address_____________________________________________________________

City ____________________________________ Postal Code _____________

Country ______________________________

## EDUCATION & TRAINING

Name of Medical School Location **(City)** Year Graduated

___________________________ /_________________/ ___________________

## If still in Training

Name of Training Program Specialty Location **(City, Country)**

Start Year _________ End Year ________

Please include a copy of your Curriculum Vitae (short like A4 page)

For further information, please contact [www.interasma.org](http://www.interasma.org)