THALASSAEMIA INTERNATIONAL FEDERATION

In official relations with the World Health Organization

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APPLICATION FORM FOR VOTING MEMBERSHIP

For requirements see attached information

We would like to register as Voting Members with one/two representative(s).

1. **Name of Association:** …………………………………………………………………………………………………..
2. **Postal Address:** ……………………………………………………………………………………………………

   …………………… Post code: ………………… City: ……………………………… Country: ………………………………

3. **Telephone Number** (Including applicable codes)**:** ……………………………………………………………………………
4. **Fax Number** (Including applicable codes)**:** ……………………………………………………………………………………
5. **E-mail address:** ………………………………………… .. **Website:** ……………………………………………………
6. **Name of representative:** ………………………………………………………………………………………………
   - **Male / Female Mr / Mrs / Miss Dr. / Prof. Position in the Association:** ………………………………..
   - **Personal Address:** ……………………………………………………………………………………………………..
7. **Name of representative** (if more than one)**:** ………………………………………………………………………………..
   - **Male / Female Mr / Mrs / Miss Dr. / Prof. Position in the Association:** ………………………………..
   - **Personal Address:** ……………………………………………………………………………………………………..
8. **Name of the President of the Association:** ……………………………………………………………………………

   Personal Address: ………………………………………………………………………………………………………..

9. **Please provide the following information regarding your Association:**

   Number of Members: ……………… **Number of Patients:** …………….. **Number of Parents:** ……… ………

MEMBERSHIP FEES

Annual Voting Fee (for one or two Representatives) EUR 200

Date of Application:……………………..……………….. **Name:** …………………………………………………..

Signature: ………………………..…………………….

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Date of Approval: …………………….. **Name/Signature:** ………………………………….