

THALASSAEMIA INTERNATIONAL FEDERATION

In official relations with the World Health Organization



THALASSAEMIA
INTERNATIONAL
FEDERATION

HEADQUARTERS

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APPLICATION FORM FOR FULL MEMBERSHIP

We would like to register as Full Member 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 Full membership Fee (for one or two Representatives) **EUR 60**

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

Signature:

FOR OFFICIAL USE ONLY

Date of Approval:

Name/Signature: