EUROPEAN SOCIETY FOR PAEDIATRIC ANAESTHESIOLOGY

MEMBERSHIP APPLICATION FORM

TITLE Prof. Dr. Mrs. Ms Mr.

To help with your registration process, please use capital letters

FIRST NAME	
LAST / FAMILY NAME	
POSITION	
DEPARTMENT	
ADDRESS 1	
ADDRESS 2	
POSTAL CODE	
CITY	
COUNTRY	
PHONE	
FAX	
E-MAIL ADDRESS	

PLEASE MARK THE APPROPRIATE FIELD

ACTIVE MEMBERSHIP Doctors who have completed an accredited training programme in anaesthesiology, and who live or work in a European country	
AFFILIATE MEMBERSHIP Doctors who have followed an accredited training in anaesthesiology and who do not live or work in a European country Doctors, nurses or other persons who work in the field of paediatric anaesthesiology	
TRAINEE MEMBERSHIP Doctors who are following an accredited training in anaesthesiology in a European country with the intention of becoming an accredited anaesthesiologist	

SEND THE FORM TO

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Date, Signature