European Chapter Integrated Health Committee Application Form

APPLICANT's NAME AND LAST NAME *: ____

IFSO MEMBERSHIP*: ☐ YES, I am an IFSO Integrated Health IFSO EC member

PLEASE STATE WHICH BARIATRIC SURGERY SOCIETY IN EUROPE YOU ARE A MEMBER OF*: _____________

AFFILIATION*: ____

DEGREE in*: ______________________________________YEAR*: ______________________________

PROFESSION: ____

PROFESSIONAL REGISTRATION NUMBER (If Applicable):____

PROFESSIONAL REGULATORY BODY WEBSITE (If Applicable):____________________________________

DATE OF BIRTH*: ____

ADDRESS*: ____

CITY*: __________________________ COUNTRY*: _____________________ ZIP: ___________________

PHONE: _________________________________ MOBILE phone*__________________________________

E-MAIL*: ____

*Mandatory field

☐ I attach the CV, the personal statement, the letter of recommendation

Date

____

Signature

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