Membership Application Form

MEMBERSHIP OPTIONS:

PERSONAL DETAILS

Title:

Category/Job Title:

Other Category/Job Title:

First Name:

Last Name:

E-mail:

Birth Date:

Academic Qualifications:

Other Area of Medical Interest/Specialization:

Area of IT Interest/Specialization:

Address:

Address 2:

City:

State/Province:

Postal Code:

Country:

Phone Number:

PROFESSIONAL DATA

Company or Institution:

Company (Public / Private):

Department / Section:

Current Position:

Address:

City:

State/Province:

Postal Code:

Country:

MAKING A PAYMENT

Select:
- ◯ Wire Transfer
- ◯ Paypal
- ◯ Direct Debit

Account Owner::

IBAN:

SWIFT/BIC:

Bank:

DATA WEB
Check the box if you agree:
- ☐ I would like to receive newsletter
- ☐ I want to appear in the directory of members

DECLARATION

As part of your membership you will have web access to our members' area where you will be able to network with other members of the Society. Please be aware that all personal information transmitted through this website is for the sole use of members only and on no account may your password or any other personal information be divulged or misused. If you fail to adhere to our terms and conditions, we may terminate, at our sole discretion, your access to this website.

I declare that the information I have supplied on this application is correct and I agree to abide by the European Society of Digital Pathology terms and conditions.

If for any reason your payment is unsuccessful, please do not submit another application. Please contact the ESDIP Team if you experience any problems.

Send to: info@digitalpathologysociety.org
