Membership HPCM

Health Professionals for Cellular Medicine

– Effective from May, 2018 –

Please complete in block letters!

Name, Surname

Street, House Number

Post Code, City, Country

Telephone

Date of Birth

Fax

E-Mail

I hereby apply for membership of the "Health Professionals for Cellular Medicine" (HPCM) association.

Membership is free of charge and can be cancelled at any time without giving reasons. Cancellation is required in writing. I am aware of the concepts and targets of the "Health Professionals for Cellular Medicine" (HPCM) association.

I am aware of the HPCM guidelines and accept that an appropriate qualifying certificate is required for membership.

Professional Data:

Profession/Activity

My special interests are:

Please mark (multiple answers possible)

☐ Cardiovascular Diseases
☐ Oncology
☐ Diabetes
☐ Rheumatic Diseases
☐ Neurological Diseases
☐ Others:

Place, Date

Signature

Please note that only fully completed applications can be dealt with. Please kindly inform us immediately of any relevant changes concerning your personal data.

1477/05-0518 GB

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