APPLICATION FOR MEMBERSHIP

EEL – European Endometriosis League

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Last name _____

First name _____

Nationality _____

Position _____

Department _____

Address _____

Phone number _____ Fax _____

Email address _____

Main professional fields of interest _____

_____

Main scientific fields of interest _____

_____

Membership fee: € 60,00 per year (including Journal of Endometriosis and reduce participation fees at EEL Congresses and Workshops).

Date _____ Signature _____

Direct Debit Authorisation

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I herewith authorise the EEL to debit my bank account for my annual member fees until further notice.

Date / Signature _____