H N H C P

Haematology Nurses & Healthcare Professionals Group

Membership Form

Please use Block Capitals or a Typewriter

Last Name: ______________________________

First Name: ______________________________

Work affiliation (hospital/other):

Name: ____

Street: ____

City: ______________________________ **Postcode:** ___________________________

Country: ______________________________ **Email address:** ________________________

Unit: **Adult unit** □ **Pediatric unit** □ **Combination** □ **Other** _____________

In the case of a centre membership please complete a seperate form for each individual member

□ **Please tick box if you do not wish your details to be given to any other organisation.**

Date: ________________________ **Signature:** ______________________________________

Return this form to:

hnhcp.group@gmail.com

Payment **40€ Individual Member; 200€ Centre Membership**

Please pay via bank transfer

Haematology Nurses & Allied Healthcare Professionals Group CH 8408 Winterthur Switzerland PostFinance
Kontonummer: 619138197CHF
IBAN: CH35 0900 0000 6191 3819 7
BIC: POFICHBEXXX

DO NOT WRITE IN THIS SPACE

Date received: ______________________________

Payment received: _______________ _______________ ________________________

Application: first □ renewal □ Member No.:

Remarks: ____

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