HNHCP
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 separate 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@hemcare.org

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: _____

_____