



MEMBERSHIP FORM

Please check the appropriate box and fill in the blanks accordingly.

TYPE OF MEMBERSHIP (PLEASE CHECK APPROPRIATE BOX):				
<input type="checkbox"/> Organization/Institution/Agency NAME OF REPRESENTATIVE: NAME OF ORGANIZATION (Please indicate position in organization):				
<input type="checkbox"/> Individual Member NAME: NAME OF ORGANIZATION/AGENCY/INSTITUTION (Please indicate position in organization):				
OFFICE/BUSINESS ADDRESS:				
TEL. NO.	CELLPHONE:	FAX NO.:	E-MAIL ADDRESS:	DATE OF BIRTH:
HOME ADDRESS (FOR INDIVIDUAL MEMBERS ONLY):				
PROFESSIONAL AND OTHER AFFILIATIONS (PLEASE INDICATE POSITION):				
DATE:			SIGNATURE:	

PLEASE SEND THE COMPLETED FORM TO FAX NO. (02) 426-1608 OR (02) 924-6507