

European Cystic Fibrosis

Pharmacy Group

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| --- |
| Membership Application |
| Name |       |
| Email address |       |
| Alternative email address |       |
| Institution |       |
| Department |       |
| Street Address |       |
| Town/County/State |       |
| Country |       | Postal/ZIP |       |
| About you |
| ECFS Membership Number |        | Unknown [ ]  I need to register [ ]  |
| Your role |  If ‘other’ please state:       |
| Specialty | Paediatrics [ ]  Adults [ ]  Both [ ]  |
| Area(s) of interest |       |
| I agree to my details being stored for the purpose of administration of the group [ ]  |
| I agree to my details being passed to a third party [ ]  |
| I do not agree to my details being passed to a third party [ ]  |
|  |       |  |       |
| Other |       | Date completed |       |
| Email form to | ecfpg@outlook.com  |