

European Cystic Fibrosis

Pharmacy Group

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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](mailto:ecfpg@outlook.com) | | | | |