**MEMBERSHIP FORM**

**Please fill in the information below completely and send it to the IMPC country representative on Fiap.net. with your portrait photo**

COUNTRY: ……………………………………………………………………………………………………………………………………………….

FIAP LIFECARD NO : (everybody must have) :……………………………………………….…………….…………………………….

FIRST NAME: ………………………………………………………………………………………………………………..…………………………

SECOND NAME: (If any):…………………………………………………………………………………………………………………..……….

FAMILY NAME: …………………………………………………………………………………………………………………………………..……

FIAP DISTINCTIONS: …………………………………………………………………………………………………………………………………

OTHER PHOTO DISTINCTIONS: ………….……………………………………………….:……………………………………………….……

GENDER: ………………………………………………………………………………………………………………………………………………..…

DATE OF BIRTH: …………………………………………………………………………………………………………………….………………..

PROFESSION: ……………………………………………………………………………………….…………………………………………………..

MEDICAL SPECIALIZATION :……………………………………………………………………………………………………………………….

ACTİVE or RETIRED: ………………………………………………………………………………….………………………………………………

E-MAIL ADDRESS: ……………………………………………………………………………..……………..………………………………………

INSTRAGRAM address: ……………………………………………………………………..…………………….……………………………….

WEBSITE address: ……………………………………………………………………………..…………………………………………………….

I declare that the personal information I have written in this membership form is correct and I share it with my own consent, provided that it is used in line with IMPC membership and its purposes.

Date:……………………………………………………………. Signature: …………………………………………………….

**PLEASE SEND A PORTRAIT PHOTO IN DIGITAL SMALL RESOLUTION WHEN SENDING THE MEMBERSHIP FORM TO YOUR COUNTRY REPRESENTATIVE.**