



MEMBERSHIP FORM

APPLICATION FORM FOR INITIAL* / ANNUAL RENEWAL* OF MEMBERSHIP

Membership Fee: Lm5

PLEASE WRITE IN BLOCK LETTERS

NAME and SURNAME _____ ID CARD NO _____

ADDRESS _____

LOCALITY _____ POST CODE _____

TEL (home) _____ TEL (work) _____ MOBILE _____

EMAIL _____

PROFESSION / GRADE _____

DEPARTMENT / SPECIALITY _____

For office use only

Application for: Ordinary Membership
 Associate Membership

Application* / Renewal* fee paid by: Cash
 Cheque (number _____)

(all cheques are to be made payable to the "Malta Resuscitation Council")

** delete as appropriate*

Application form processed by _____ on behalf of the
Malta Resuscitation Council.

Signature _____ Date _____

MALTA RESUSCITATION COUNCIL

PO BOX 04, ZEBBUG
www.resus.org.mt