

MEMBER

APBMT Membership Application Form

PHOTOGRAPH

Please print clearly

Last name:		First name:	
Qualifications: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> Nursing qualification <input type="checkbox"/> Other specify _____			
Department:			
Institution:			
Address:			
City:		Province / Prefecture:	
Postal code:		Country:	
Phone:		Fax:	
e-mail:			

COMMITMENT: By signing below, I certify that I am actively involved in the scientific and clinical area of blood or marrow transplantation (or transplantation of other haematopoietic tissue).

Date: _____

Signature: _____

RECOMMENDATION: I recommend this person highly as a regular member of the APBMT.

Date: _____

Signature: _____

Please send the completed form to the following address;

Secretary's Office of APBMT

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Nagoya University, School of Medicine
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TEL +81-52-719-1973 / FAX +81-52-719-1973

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