

International Hepato-Pancreato-Biliary Association



IHPBA

APPLICATION FOR MEMBERSHIP

Please print in black ink, clearly & in block letters.

Preferred Title:	Prof.	Dr.	Mr.	Mrs.	Ms.
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Family/Surname:	First Name:
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Date of Birth:	Citizenship in which Country:
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Business Address (please be sure to include ZIP code):		
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Phone:	Fax:	*Email:
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Home Address (please be sure to include ZIP code):		
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Phone:	Fax:	*Email:
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Please check preferred Address:	Business	Home
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*Please provide your email address as this is the main method of communication.

Academic or Other Degrees:		
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Medical School:	Graduation Date:
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*****Complete back page of Membership Application & Subscription Payment Form*****

IHPBA Executive Secretariat

Medconnect GmbH

Bruennsteinstr. 10, 81541 Munich, Germany

Tel: +49-89-4141-9249 Fax: +49-89-4141-9245 Email: Heather.Wynn@medc.de

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APPLICATION FOR MEMBERS (Page 2)

Further Training

Hospital	City/Country	From (yr)	To (yr)	Type

Please make a check mark on the following:

Primary Speciality:	Surgery	Gastroenterology
	Radiology	Other
Are you engaged in teaching?	Yes	No
Are you engaged in research?	Yes	No

Present Hospital/University Affiliations

Hospital/University	City	Your Title

Are you a member of an IHPBA National Chapter?	Yes	No
If so, please specify name		

Candidate's Signature:	Date:

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