

APPLICATION MEMBERSHIP INTERNATIONAL CONSORTIUM FD/MAS

WWW.ICFDMAS.COM

PERSONAL INFORMATION	
Full name:	
Email address:	
Organization:	
Reason for applying:	
Memberships of professional societies:	
Primary field of interest:	
I am a:	<ul style="list-style-type: none">• Clinician• Clinician - scientist• Basic researcher• Patient organization representative*• PhD student

DECLARATION AND SIGNATURE
<p>I, _____, hereby declare that the above information provided is true and complete to the best of my knowledge. I agree to abide by the consortium's Terms of Reference. I understand that any false information may result in the denial of membership or termination if already accepted.</p> <p>If membership is granted I approve that my name will be listed as a consortium member on the ICFDMAS website.</p>
Signature:
Date:

Please send this application with a C.V. to info@icfdmas.com

* For patient organization representatives there is no need for a CV.

Please provide relevant links to your website and/or social media platform.