

Membership Application

Name of company

Head office address

Telephone(s)

Office

After hours

Mobile

Fax

Email

Website

Main contact person's name

Branch office address

Name(s) of proprietor(s)

Name(s) of Director(s)

Form of organisation (Limited, etc.)

Company registration number

Date business established

Membership Application

| | | |
|---|---|---|
| <u>Name and address of Bankers</u> | | |
| | | |
| <u>Are you a member of any shipping related associations? Please list:</u> | | |
| | | |
| Referees - please supply names and e-mail addresses of at least 3 companies we may approach for a reference | | |
| Company name | Contact name | Email address |
| | | |
| | | |
| | | |
| <u>What is the annual volume of business in US\$</u> | | |
| 50,000 to 250,000 <input type="checkbox"/> | 250,000 to 500,000 <input type="checkbox"/> | 500,000 to 750,000 <input type="checkbox"/> |
| 750,000 to 1 million <input type="checkbox"/> | Above 1 million <input type="checkbox"/> | |
| <u>Why do you want to be an IMMA member/what benefit do you foresee in being an IMMA member?</u> | | |
| | | |
| After your application is approved a user account will be created for you to log in to the member's area of this website. Please enter the username that you want to use | | |
| | | |
| Payment method: Credit Card or Bank Transfer (contact secretariat for details). No Cheques. | | |
| Credit card <input type="checkbox"/> Bank Transfer <input type="checkbox"/> | | |
| Please refer to the on-line scale of Membership Fees at www.maritime-medical.org/whyjoin.php | | |
| | | |
| Total payable: | Name on card: | |
| Card type: Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> | | |
| Card Number: | | |
| Date of Expiry: | Security number: | Signature: |
| | | Date: |

**After completion, please send this form to: International Maritime Medical Association
The Baltic Exchange, 38 St Mary Axe, London EC3A 8BH or e-mail: secretariat@maritime-medical.org**

Supplemental doctor/clinic information

| | |
|--|--|
| <u>Name of clinic</u> | |
| <u>Medical University</u> | |
| <u>Clinic address</u> | |
| <u>Principal Doctor</u> | |
| <u>Telephone</u> | <u>Fax</u> |
| <u>Hours of operation</u> | <u>After hours coverage</u> |
| <u>Best way to get to your clinic</u> | |
| <u>Services available</u> | |
| Do you have X-ray on the premises? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you make shipboard calls? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <u>Do you provide vaccinations such as yellow fever, typhoid and cholera? (please list)</u> | |
| <u>Hospital affiliation, or which hospital do you refer the patient to?</u> | |
| <u>Additional comments</u> | |