IMO Membership Application Form for Public Health Doctors / Community Health Doctor

Work Telephone:

Mobile No:

Email Address:

University Attended:
Year of Graduation:



Personal Details: Please tick appropriate box where applicable: Surname: **Public Health Doctor** Community Health Doctor Forename: Date of Birth: **Full Single** Male Female Current Grade: Home Address: Work/Practice Address: CHO Area: Please tick Address IMO correspond to: Home **Practice Surgery** Home Telephone:

Applicants must hold qualifications, which are acceptable for registration with the Medical Council of Ireland.

I consent to IMO Financial Services contacting me regarding the financial products and services available to me as a members of the IMO which may be of interest to me. If you wish us to forward your contact details to IMOFS and be contacted by IMOFS in writing, by email, by landline and mobile phone, SMS text and fax electronic, please tick this box:

Registration No:

Category of Registration with Medical Council number:

SEPA Direct Debit Mandate



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By signing this mandate form, you authorise (A) the Irish Medical Organisation to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from the Irish Medical Organisation.

As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with vour bank.

explained in a statement that you can obtain from your bank.

A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are Please complete all the fields marked * М C S D Α L Creditor's name 0 R G A N S A T ī 0 Ν Creditor identifier т Е 7 0 S D D 3 0 0 0 5 4 Creditor address C Ē 1 0 F ī T Z W ī Ĺ Ĺ Ī A M P Ĺ A City D U В Ĺ ī N 2 Post Code Country R Е L A N D Type of payment Recurrent payment One-off payment **Debtor Name*** Debtor Address* Citv* Post Code* Country* Debtor account number IBAN* Debtor bank identifier code BIC* Date of signature* Signature(s) Please sign here* Please return this mandate to the Creditor

For Information Purposes Only:		
Recurring Payment Schedule: (Please tick as appropriate)	Monthly	Annual

^{*} Unique Mandate Reference (UMR) – (For official use only)