## IMO Membership Application Form for General Practitioners



Applicants must hold qualifications, which are acceptable for registration with the Medical Council of Ireland. Surname: Forename: Date of Birth: Male Female Home Address: Practice/Surgery Name: Address: Please tick Address IMO correspond to: Home Practice / Surgery Home Telephone: Work Telephone: Mobile No: **Email Address:** Year of Graduation: University Attended: Category of Registration with Medical Council number Registration No: Please tick appropriate box where applicable: GP Newly Established (5 years) Full Single **GP Locum** Academic **GP Assistant Year Primary Care Reimbursement Services** Are you in the GMS Scheme? GMS No **GMS Authorisation Form** Primary Care Reimbursement Services, Exit 5, M50, North Road, Finglas I hereby authorise the Primary Care Reimbursement Services to deduct my monthly IMO subscription per month with effect from **Full Single** Signed: Date:

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:

## 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 N 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

<sup>\*</sup> Unique Mandate Reference (UMR) – (For official use only)