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

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

Personal Details:

Surname: ....

Forename: ....

Date of Birth: ....

☐ Male ☐ Female

Home Address: ....

....

....

Work/Practice Address: ....

....

....

Please tick Address IMO correspond to:

☐ Home ☐ Practice Surgery

Home Telephone: ....

Work Telephone: ....

Mobile No: ....

Email Address: ....

University Attended: ....

Year of Graduation: ....

Please tick appropriate box where applicable:

☐ Public Health Doctor

☐ Community Health Doctor

☐ Full Single

Current Grade: ....

....

....

....

....

CHO Area: ....

....

....

....

....

Category of Registration with Medical Council number:

Registration No: ....

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

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Unique Mandate Reference [ ]

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

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 your bank.

A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

Please complete all the fields marked *

Field	Value
Creditor's name	IRISH MEDICAL ORGANISATION
Creditor identifier	IE70SDD300054
Creditor address	10 FITZWILLIAM PLACE
City	DUBLIN 2
Post Code	
Country	IRELAND

Type of payment	**Recurrent payment** ✓ or **One-off payment** [ ]

Field	Value
Debtor Name*	
Debtor Address*	
City*	
Post Code*	
Country*	
Debtor account number IBAN*	
Debtor bank identifier code BIC*	
Date of signature*	
Please sign here*	Signature(s)

Please return this mandate to the Creditor

For Information Purposes Only:

Recurring Payment Schedule: (Please tick as appropriate) **Monthly** [ ] **Annual** [ ]

IMO House, 10 Fitzwiliam Place, Dublin 2. Tel: 01 6767273 Email: imo@imo.ie