

IMO Membership Application Form for Consultants



IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

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:

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Work Address(es):

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Please tick Address IMO correspond to:

Home Work

Work Telephone:

Mobile No:

Email Address:

University Attended:

Year of Graduation:

Category of Registration with Medical Council number:

Registration No:

Please tick appropriate box where applicable:

- Newly Appointed Year 1
- Newly Appointed Year 2
- Newly Appointed Year 3
- Full Single
- Locum
- Dentist
- Non Clinical Academics
- Temporary

Speciality:

- Anaesthesia
- Emergency Medicine
- Medicine
- Obstetrics/Gynaecology
- Orthodontics
- Pathology
- Paediatrics
- Psychiatry
- Radiology
- Surgery
- Other

Subspeciality:

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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
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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 *

Creditor's name	I	R	I	S	H	M	E	D	I	C	A	L								
	O	R	G	A	N	I	S	A	T	I	O	N								

Creditor identifier	I	E	7	0	S	D	D	3	0	0	0	5	4						
Creditor address	1	0		F	I	T	Z	W	I	L	L	I	A	M	P	L	A	C	E
City	D	U	B	L	I	N	2												
Post Code																			
Country	I	R	E	L	A	N	D												

Type of payment Recurrent payment or One-off payment

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