IMO Membership Application Form for General Practitioners

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Applicants must hold qualifications 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: _____

University Attended: _____ Year of Graduation: _____

Category of Registration with Medical Council number

Registration No: _____

Please tick appropriate box where applicable:

☐ GMS Principal/ Partner ☐ GP Locum ☐ Academic ☐ 1-3 Year Post Qualification ☐ 4-6 Years Post Qualification

Primary Care Reimbursement Services

Are you in the GMS Scheme? ☐ Yes ☐ No 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 _____

☐ GP Principal/Partner

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

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**	p	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** ☐