NCHD IMO Membership Application Form



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

Personal Details:	Please tick appropriate box where applicable:
Surname:	Intern
Forename:	Senior House Officer Year:
Date of Birth:	GP Trainee Year:
Male Female	Registrar Year:
Home Address:	Senior Registrar
	Specialist Registrar
	Research/Postgraduate/Fellowship
Work Address(es):	Subspeciality:
Address IMO correspondance (please tick one):	Category of Registration with Medical Council number: Registration No:
Home Work	
Home Telephone:	
Work Telephone:	
Mobile No:	
Email Address:	
University Attended:	
Year of Graduation:	

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 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)