



European Society of Clinical Neuropharmacology

APPLICATION FOR MEMBERSHIP

Name:

Title: Date of Birth:

Office Address:

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Home Address:

.....

.....

E-mail Address:

Tel. No (work): Fax No (work):

Profession mainly as clinician () yes () no

mainly as basic scientist () yes () no

Special interests:

Please indicate your research areas, interests, or specialities (up to four):

1.

2.

3.

4.

I wish to apply for Individual Membership.

.....

Date

.....

Signature of Applicant

Please print and send to:

ESCPN
by GUARANT International s.r.o.
Opletalova 22
110 00 PRAGUE 1
Czech Republic
Tel. No: +420 284 001 444
Fax No: +420 284 001 448
E-mail: kralova@guarant.cz