Irish Association of Sterile Services Managers (I.A.S.S.M.)

Membership Application Form

DATE: _____

NAME: _____

ADDRESS (WORK):

_____

_____

E-MAIL:_____

TELEPHONE:_____ **FAX:**_____

POSITION:_____**DEPARTMENT:**_____

ADDRESS FOR CORRESPONDENCE:_____

_____

FULL MEMBERSHIP (€30): ❑

ASSOCIATE MEMBERSHIP (€15): ❑

PLEASE RETURN APPLICATION FORM TO:
CAROLINE CONNEELY, C.S.S.D., CHILRENS UNIVERSITY HOSPITAL
TEMPLE STREET DUBLIN 1, IRELAND. TEL: +353-1-8784252.

OFFICIAL USE ONLY

MEMBERSHIP APPROVED: YES NO

APPROVAL DATE:_____

APPROVED BY:_____