Royal College of Surgeons in Ireland.
123 St Stephen's Green,
Dublin 2,
Ireland.
www.iaem.ie
www.emergencymedicine.ie

IAEM Associate Membership Application Form

PROFESSIONAL DETAILS

Title: _____ First Name: _____

Surname: _____

Current post: _____

Category: SpR ☐ Registrar ☐ SHO ☐ Intern ☐ Staff Grade ☐ AEP ☐ Other (specify): _____

Work Address: _____

_____

CONTACT DETAILS

Preferred contact address: Work ☐ Other ☐

Other Address: _____

_____

_____

Work telephone No: _____ **Email:** _____

Mobile telephone No: 08_____

NEW ASSOCIATE MEMBERSHIP

Complete form and attached Direct Debit Mandate legibly using block capitals. Send both to the ***Honorary Secretary****. Once notified of membership approval your mandate will be processed.*

PAYMENT

Annual Subscriptions are due on 1st January of the subscription year but payment by Direct Debit will be deferred until 1st February of the year. **The current subscription rates are detailed on www.iaem.ie. Please note that there is a significant discount if paying by Direct Debit.**

I hereby apply for Membership of the Irish Association for Emergency Medicine. I agree to abide by the Constitution and rules of the Association.

SIGNED: _____ DATE: _____

President:
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SEPA Direct Debit Mandate

Unique Mandate Reference (UMR)	
	(for office use only)
Creditor Identifier	IE60ZZZ306636
Creditor's Name	**Irish Association for Emergency Medicine**
Address	**Royal College of Surgeons of Ireland**
	123 St Stephen's Green
City / Post Code	**Dublin 2**
Country	**Ireland**

Legal Text: "By signing this mandate form, you authorise (A) the Irish Association for Emergency Medicine to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from the Irish Association for Emergency Medicine. 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 *

Your Surname*	
Your First Name(s)*	
Name on account to be debited *	
Your Address*	
Your City / Post Code*	
Your Country*	
Your Bank*	
Your Bank Address*	
Your IBAN * (Top right of your bank statement)	
Your Bank Identifier Code (BIC)*	

Type Of Payment* Recurrent Payment ☐ **or** One-off Payment ☐ (Please tick √ one box only)

Date Of Signature* D D M M Y Y Y Y

Signature(s)

Please Sign Here*

Please return this mandate form to:

Mr. M. Ashraf Butt
Honorary Secretary, Irish Association for Emergency Medicine
Emergency Department,
Cavan General Hospital,
Cavan
Co Cavan