WORLD SOCIETY OF DISASTER NURSING

Membership Application Form

ORGANIZATION INFORMATION					
Name of Organization					
Address					
	Country				
	TEL		FAX		
	URL				
Type of Organization	☐Academic Institution ☐Healthcare Institution ☐Professional Organization ☐Others				
Objectives of Organization					
Activities conducted by Organization					
Date of the organization founded	Year	Month	Day		
Number of members from the organization					

REPRESENTATIVE INFORMATION					
Name of representative	☐Dr. ☐Professor ☐Mr. ☐Ms. ☐Miss. ☐Mrs.				
	Family Name		Given Name		
	Middle Name				
Position (Role)					
Contact information	Email				
	TEL		FAX		
If there is another contact person than the above representative, please fill out the following					
Name of the person	☐Dr. ☐Professor ☐Mr. ☐Ms. ☐Miss. ☐Mrs.				
	Family Name		Given Name		
	Middle Name				
Position (Role)					
Contact information	Email				
	TEL		FAX		

Date of completion:

yyyy/mm/dd

*Secretariate Section

Received:	yyyy/mm/dd	Approved:	yyyy/mm/dd