I, the undersigned, declare that the information provided by me is true and undertake to notify any changes within 30 days of their occurrence.

|  |  |  |
| --- | --- | --- |
| **Personal data** | | |
| Permit/license number\* |  | |
| Name used in healthcare\* |  | |
| Birth name\* |  | |
| Name on the identity card\* |  | |
| Date of birth\* | \_\_ \_\_ \_\_ \_\_ (year) \_\_ \_\_ (month) \_\_ \_\_ (day) | |
| Place of birth\* |  | |
| Parent’s name on the identity card |  | |
| Gender\* | male ⬜ / female ⬜ | |
| Personal number\* | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | |
| Home address\*  (by personal number) | Postcode: | |
| Settlement: | |
| Address:  (street, house no.,  floor, door) |  |
| Mailing address\* | Postcode: | |
| Settlement: | |
| Address:  (street, house no.,  floor, door) |  |
| E-mail address\* |  | |
| Phone number\* |  | |

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| **Qualification data** | |
| Year of graduation\* | \_\_ \_\_ \_\_ \_\_ (year) |
| Diploma number |  |
| Name of the institution issuing the diploma |  |
| Diploma type\* | general medical ⬜ *or* dental ⬜ *or* non-medical ⬜ |
| Diploma issuer\* | Educational institution from Hungary ⬜  Diploma obtained abroad ⬜  Nostrification of diploma ⬜  Diploma from Serbia ⬜ |
| I have a specialist examination / medical specialisation\* | yes ⬜ no ⬜ |
| Name of medical specialisation\* |  |
| Year of specialist examination / medical specialisation\* | \_\_ \_\_ \_\_ \_\_ (year) |
| Issuer of medical specialisation |  |
| Language exam\* | yes ⬜ no ⬜ |
| Degree, type of language exam |  |
| Issuer, year of language exam | \_\_ \_\_ \_\_ \_\_ (year) |
| Knowledge of foreign languages without an exam\* | yes ⬜ no ⬜ |
| List of foreign languages and your assessed level of knowledge |  |
| I have other diploma/degree\* | yes ⬜ no ⬜ |
| Type of other diploma/degree (PhD) |  |
| Year of other diploma/degree | \_\_ \_\_ \_\_ \_\_ (year) |
| Number of other diploma/degree |  |
| Issuer of other diploma/degree |  |

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| **Employment data** | |
| Name of workplace\* |  |
| Address of workplace\* |  |
| Phone number of workplace |  |
| Position, job title\* |  |
| Department\* |  |
| Date of entry into the current job | \_\_ \_\_ \_\_ \_\_ (year) |
| Medical work experience | \_\_\_\_ years |
| Specialist work experience | \_\_\_\_ years |
| Retirement since (if the answer to the following question is yes) | \_\_ \_\_ \_\_ \_\_ (year) |
| Working in retirement\* | yes ⬜ no ⬜ |

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| **Billing information**  (please fill in only if you request an invoice on membership fee, issued for your company) | |
| Billing (company)name\* |  |
| Billing address\* |  |
| Billing (company) tax number |  |

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| **Membership fee payment data, statements \*** | | |
| Method of paying the membership fee | | ⬜ by bank transfer in equal monthly instalments, by the 10th of the current month |
| ⬜ by bank transfer in two equal annual instalments, by 31st March and 30th September of the current year |
| ⬜ by bank transfer in one amount per year, until 31st March of the current year |
|  |
| ⬜ | I request full membership fee exemption because I am over 70 years old. | |
| ⬜ |  | |

Date: ………………………………………..

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signature

seal