MEMBERSHIP FORM

إتحاد المستشفيات العربية
ARAB HOSPITALS FEDERATION

Full Name ______________________________

______________________________ الإسم الكامل

Specialization ______________________________

______________________________ الإختصاص

Current position ______________ Institution ______________

______________ المؤسسة ______________ الوظيفة الحالية

Address ______________________________

______________________________ العنوان

Country ______ City ______ Mobile ______________

______________ رقم الخليوي ______ المدينة ______ البلد

Email ______________________________

I want to join the Arab Hospitals Federation as :

☐ Individual Member

Please Attach CV and Passport Copy

Signature

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It can be paid by

- Cash
- Bank Transfer

Details will be available on the invoice

Annual Membership fees per Individual:

- 500 USD