EADO Affiliated Organization
Application Form

Organization Name: ____

Address: Street/Avenue: _____________________________________Number:______

City: ___________________Postal Code______________Country: ___________________

Telephone: (+) _______________________Mobile: (+)_____________________________

Fax: (+) ________________________E-mail address: ____________________________

Website:______________________________Date of legal establishment:_____________

Organization's aim:____

____

Organization Leadership:

President

Name ____Title:___________

Position: _______________________________________

Telephone: (+) ____________________________ e-mail_________________________

Vice-President

Name ____Title:___________________

Position: _______________________________________

Telephone: (+) ____________________________ e-mail_______________________

Secretary

Name ____Title:__________________

Position: _______________________________________

Telephone: (+) ____________________________ e-mail________________________

Organization activity:

Number of organization's registered members at the date of application: ______________

Please state **3 projects** or activities in the field of dermato-oncology carried out by your organization in the last 3 years (e.g. research, educational activities, public education campaigns etc.)

1.____

2.____

3.____

Organization's Designated Representative to EADO

Name ____Title:_________________

Position: ____

Telephone: (+) ____________________________ e-mail______________________

Date____________ Signature_________________________