European Endometriosis League

APPLICATION FOR MEMBERSHIP

EEL – European Endometriosis League

Franziska Srp-Cappello EEL General Office franziska.srp@conventus.de Fax: +49 3641 3116-243	Engin Oral, Prof MD EEL President drenginoral@gmail.com

Last name ____

First name ____

Nationality ________________________Position ____

Department ____

Address ____

Phonenumber____________________________________Fax_________________________________

Email address ____

Membership fee: **€ 60,--** per year (including Journal of Endometriosis and reduce participation fees at EEL Congresses and Workshops).

Date Signature

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SEPA Direct Debit Mandate for SEPA Core Direct Debit Scheme

Bank _______________________________________

IBAN ______/______/______/______/___________

SWIFT/BIC-Code______________________________

I herewith authorise the EEL (Creditor Identifier: DE14ZZZ00001197085) to debit my bank account for my annual member fees (mandate reference = membership number) until further notice. As part of your rights for recurrent payments you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimend within 8 weeks starting from the date on which your account was debited.

Date / Signature ____________________________________