

Title _____
First Name _____
Last Name _____
Address _____
City _____ Postcode _____ Country _____
Phone _____ Fax _____
Email _____

Please indicate membership category

	1 year	3 years
Full membership (European Ophthalmologists only)	€ 150 <input type="checkbox"/>	€350 <input type="checkbox"/>
International membership (Non European Ophthalmologists)	€ 150 <input type="checkbox"/>	€350 <input type="checkbox"/>
Non medical visual scientist (European and Non European Visual Scientists)	€ 150 <input type="checkbox"/>	€ 350 <input type="checkbox"/>
Trainee *	FREE OF CHARGE <input type="checkbox"/>	

Please supply letter of verification from your training hospital for trainee membership. Your application cannot be processed without this letter.

PAYMENT METHOD

Payment can be made by bankdraft in Euro payable to the ESCRS, or by credit card giving the following details:

VISA MASTERCARD

CARD NUMBER: EXP: 3 Digit Security Code

Signature: _____ Date: _____ *Please indicate if you do not wish to have your details included on a list of ESCRS members*

1. Year of birth _____

2. What is your speciality / professional classification?
- a. Practising ophthalmologist
 - b. Ophthalmic / Medical trainee
 - c. Ophthalmic Nurse
 - d. Ophthalmic Technician
 - e. Optomotrist / Optometry specialist
 - f. Medical professional
 - g. Individuals in the pharmaceutical sector
 - h. Others _____

4. Other fields of interest (Select all that apply)
- a. Cataract Surgery
 - b. Refractive surgery
 - c. Glaucoma
 - d. Vitreous / Retinal disorders
 - e. Corneal / External Eye Disease
 - f. Paediatrics
 - g. Oculoplastic
 - h. Neuro-Ophthalmology
 - i. Pathology
 - j. Other _____

3. Primary field of interest (Select one only)
- a. Cataract Surgery
 - b. Refractive surgery
 - c. Glaucoma
 - d. Vitreous / Retinal disorders
 - e. Corneal / External Eye Disease
 - f. Paediatrics
 - g. Oculoplastic
 - h. Neuro-Ophthalmology
 - i. Pathology
 - j. Other _____

5. Which best describes the setting of your practice?
- a. Hospital based
 - b. Private practice
 - c. Office based
 - d. Other _____

Please complete the form and send it to
ESCRS, Temple House, Temple Road, Blackrock,
Co. Dublin, Ireland
Tel: +353 1 2091100 • Fax: +353 1 2091112
Email: membership@escrs.org