



Israeli Medical Association World Fellowship

APPLICATION FORM

I hereby apply for admission to the IMA as a member of the World Fellowship (Please print):

Qualified Physician

First Name:	Surname:
Dr/Prof:	
Home Address:	
Work Address:	
Field of Medicine:	
Tel. No.	E-mail Address:
Mobile no.	Fax:

Medical Student

First Name:	Surname:
Home Address:	
School:	
Year of Graduation:	
Tel. No.	E-mail Address:
Mobile no.	Fax:

In addition to the main organization, we have also IMA WF chapters abroad, which are created through local organization of World Fellowship members on a national basis .

I agree/disagree that my contact details can be given to other members and/or to IMA WF chapters abroad

Signature

Date

* Please return the completed form to International Public Relations Officer –
Email: international@ima.org.il or by fax +972 3 6100477