AFACOT

Association Franco-Allemande des Chirurgiens Orthopédistes et Traumatologues

Herewith I submit my application to be accepted as an ordinary member

Name _____ Given name _____ Title _____

Please provide your home address:

Street _____ Email address (mandatory) _____

Postal code, City _____ Phone number (private) _____

Country _____ Date of Birth _____

Function:

- ☐ Resident
- ☐ Consultant
- ☐ Senior consultant
- ☐ Head of department
- ☐ Medical director
- ☐ Section head
- ☐ Practitioner

Earlier function, activity, membership in other medical or professional organizations of particular interest: _____

Consent to the processing and use of personal data:

In accordance with the General Data Protection Regulation, it is pointed out that for the purposes of member administration and member information, the requested member data is stored, processed and used in automated files. You can revoke your consent as a whole or with regard to individual measures at any time with effect for the future.

☑ I consent to the collection, processing and use of personal data by the association for the purpose of member administration and member information by means of electronic data processing. I am aware that the application for membership cannot be granted without this consent.

Place and date _____ ✘ _____ Signature