Deutsche Gesellschaft für Zahn-,
Mund- und Kieferheilkunde e.V.
Liesegangstraße 17a
40211 DÜSSELDORF
DEUTSCHLAND

MEMBERSHIP APPLICATION FORM
TO THE GERMAN SOCIETY OF DENTAL, ORAL AND CRANIOMANDIBULAR SCIENCES

Your Personal Dates (please print)

Titel: _____

Christian name: _____

Surname: _____

Date of birth: _____

Date of graduation: _____

Date of doctor diploma: _____

Office Address

Postbox: _____

Street: _____

Country: _____

Zip Code, City: _____

Telephone-No: _____

Fax-No: _____

Private Address

Street: _____

Country: _____

Zip Code, City: _____

Telephone-No: _____

Bank account

By signing this mandate form, you authorise the DGZMK to send instructions to your bank to debit your account and your bank to debit your account in accordance with the instructions from the DGZMK.

It is possible to get reimbursed for the amount which was deducted from my account within a time period of 8 weeks. The agreed conditions of my bank apply.

BIC: _____

_____

IBAN: _____

Fee:

EUR	95,00	Full member
EUR	85,00	Full member, at the same time member of an associated society
EUR	75,00	Full member, at the same time member of a corporately attached society to the GSDOM
EUR	30,00	assistant doctors up to the 2nd year after graduation (Subject to leastwise 1 year membership in the DGZMK as student)
EUR	65,00	assistant doctors up to the 3rd year after graduation (enclose proof)
EUR	0,00	Student
EUR	0,00	Member older than 65 (on application)
EUR	500,00	Firm/Company
EUR	75,00	Scientist without graduation
EUR	50,00	non-academic persons involved in delivery of dentistry (extraordinary membership)

Other

I am interested in the membership in the APW: □ O Yes □ O No

Study group of: _____

Decorations: _____

Date of decoration: _____

Date: _____ Signature: _____
Mark

State: 01/2013