

**THE GERIATRIC MEDICINE SOCIETY OF MALTA
Membership Application Form**

P.O. Box 51, MTP Branch, Qormi Road, Marsa, MTP1000

☎: 79345512 email: info@gmsmalta.com & gmsmalta@gmail.com

1. Surname			
2. Name			
3. Home Address			
4. Work Address			
5. E-mail address			
6. Mailing Address	Home Address <input type="checkbox"/> Work Address <input type="checkbox"/> e-mail <input type="checkbox"/> (tick one)		
7. ID number			
8. Telephone		9. Mobile number	
10. Malta Medical Council Reg. No			
11. Qualifications (Higher Degree/Diploma) in Geriatric Medicine/Gerontology*	Date of Degree/Diploma	University/Institute	
12. Current Appointment / Practice in Geriatric Medicine			
13. Date of Commencement of your current Practice in Geriatric Medicine			
14. If no longer Practicing in Geriatric Medicine, indicate the Duration of your Practice in Geriatric Medicine			
Date of Commencement		Date of Termination	
15. Current Appointments / Practice in Allied Medical Specialties (eg Psychiatry, Family Medicine)			
16. Brief Account of any Published Research on Care in Older Persons*			

17. Declaration: I, the undersigned, whose details are written above, wish to apply for Membership in 'The Geriatric Medicine Society of Malta' for the Year

FEES (tick one only)	
Ordinary Membership	€25 per annum
Associate Membership	€15 per annum

Signature of Applicant

*use reverse side of this form if necessary

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Date Received		Date approved by the Society	
Membership Status		Official's Signature	
Payment Details	(€25,€15) in (cash/cheque)	Bank & Cheque No.	
Received by		Receipt No.	

The information provided in this form will be solely used by The Geriatric Medicine Society of Malta in accordance with the Data Protection Act. The Geriatric Medicine Society of Malta is committed to respect your privacy in accordance with the Malta Data Protection Act 2001 and the General Data Protection Regulation (EU) 2016/679.