

APPLICATION FOR MEMBERSHIP

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Nationality _____ Position _____

Department _____

Address _____

Phonenumber _____ Fax _____

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Membership fee: € 60,-- per year (including Journal of Endometriosis and reduce participation fees at EEL Congresses and Workshops).

Date _____ Signature _____

SEPA Direct Debit Mandate for SEPA Core Direct Debit Scheme

Bank _____

IBAN ____/____/____/____/____

SWIFT/BIC-Code _____

I herewith authorise the EEL (Creditor Identifier: DE14ZZZ00001197085) to debit my bank account for my annual member fees (mandate reference = membership number) until further notice. As part of your rights for recurrent payments you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited.

Date / Signature _____