European Cytogeneticists Association

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☐ **APPLICATION FOR MEMBERSHIP** ☐ **NOTIFICATION OF CHANGE OF ADDRESS**

NAME: _____ SURNAME: _____

ACADEMIC DEGREE: _____
(M.D., D.Sc., Ph.D., ete)

MAiN WORK TOPIC(S): _____
(i.e. Prenatal Cytogenetics, Cancer Cytogenetics)

INSTITUTION: _____

POSITION HELD: _____

Street / PO Box: _____

CITY: _____ ZIP CODE: _____

COUNTRY: _____

TELEPHONE: _____ FAX: _____ E-MAIL: _____

PRIVATE ADDRESS (optional): _____

TELEPHONE: _____ FAX: _____ E-MAIL: _____

MEMBERSHIP FEE: € 120 for 3 years
(Reduced fee for Eastern Countries and cytogenetic technicians: € 30 for 3 years)

☐ **REGULAR / ASSOCIATE MEMBER**

☐ **REGULAR / ASSOCIATE MEMBER (EASTERN COUNTRIES)** ☐ **TECHNOLOGIST**

METHOD OF PAYMENT:

☐ **Please charge to Visa / Eurocard:**

CARD NO: _____

EXP. DATE: _____

NAME ON CARD: _____

CARD VERIFICATION VALUE: _____

(Last 3 digits at the back of your card)

For online payment you will receive your password after you have become an E.C.A. Member

D **Bank Transfer:**

If you prefer to pay by Bank Transfer

Bank Name: T.Garanti Bank.A.S.
Swift Code: TGBATRISXXX
Account Name: Dekon Congress & Tourism
Branch Name: Boğaziçi Ticari Branch (1666)
Account Number: 9085798 Euro
IBAN: TR46 0006 2001 6660 0009 0857 98

Please note that for both Bank Transfer and Payment by Cheque, there will be a significant additional fee to cover bank charges. Please make sure that the transfer/payment is free of charge for the beneficiary. in case of insufficient payment the administration office will send you an invoice for the remaining amount. Please make sure that the name of the member is indicated on the bank transfer.

D **I hereby state that I support the scientific and clinical goals of the E.C.A.**

Date: Signature

Please return this application form by fax to DEKON Congress & Tourism
For the attention of Merve Dagli: + 90 212 347 63 00 or as e-mail to mervedagli@dekon.com.tr