

Membership application form

EAHSA is happy to welcome you as a member !!!
Please fill in the blank fields in this form to register as a member.

Name: _____

Company: _____

Adress: _____

Zip Code: _____

City: _____

Country: _____

Tel. Nr (incl. countrycode for example: +32 45 1234567):

E-mail: _____

Signature: _____

Membership category (please tick one of the categories):

<input type="checkbox"/>	EAHSA Membership Category
<input type="checkbox"/>	Care providers
<input type="radio"/>	Budget <€ 50 Mio/year
<input type="radio"/>	Budget >€ 50 Mio/year
<input type="radio"/>	National/regional association
<input type="checkbox"/>	Business
<input type="radio"/>	Revenues <€ 50 Mio/year
<input type="radio"/>	Revenues >€50 Mio/year
<input type="radio"/>	Individual professionals
<input type="checkbox"/>	Public Sector (administration, agencies, etc.)
<input type="radio"/>	Local organisation
<input type="radio"/>	National or regional organisation
<input type="radio"/>	Academic Institution

EAHSA will send you an invoice by e-mail after you are registered as a member.

We thank you very much for your confidence in us and we hope that you will benefit highly from your membership !!