香港神經外科學會有限公司
THE HONG KONG NEUROSURGICAL SOCIETY LIMITED
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Hong Kong Stereotactic Radiosurgery (HKSRS) Chapter

Affiliate Membership Registration Form

Name : ___Dr./Mr./Mrs./Ms.____ (   )

Office Address : ____

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Office Tel. No. : ____________________ **Fax. No. :** ____________________________

Mobile Phone No. : _________________ **E-mail Address :** _______________________

Present Post : ____

Professional Qualifications (with year) : ____

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Other Academic Societies : ____

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I *do/do not object to disclosing my personal data to other parties for the purpose to facilitate scociety activites, scientific exchange and relevant scoial activites with Federation of Medical Societies and the like.

Date of application: ______________ *Applicant's Signature:* _____________________

Seconded by: (a member / affiliated member)

Names: _________________________ *Signature:* _________________________

For Official Use:

Approved by:_________________________ **Date:** ___________________________

Inform applicant on: __________________