

Application Form

Application for Individual () co-operative () membership*

Please fill out electronically or print readable. **Not valid without signature.**

Profile (*=mandatory)

Mr./Mrs. _____ Title _____

First name* _____ Last name* _____

Occupation: _____

Clinic/institution/company* _____

Department/specialization* _____

Street* _____

Country* _____ ZIP* _____ City* _____

Phone* _____ Fax _____

E-Mail* _____ Website _____

I read and agree to the articles of association (bylaws). The annual membership fee is 50 EUR.

I am dealing with sacroiliac research or treatment since (year)* _____

The application will be confirmed by the SIMEG executive committee. Payment details for the membership fee and access to the SIMEG server will be forwarded together with the confirmation of membership.

Date _____ Signature _____

Please return by mail or Fax to:

Sacroiliac Medical Experts group
c/o M. Dierks
Hinterhufe 106

42929 Wermelskirchen/Germany

Fax: +49 2196 732 536

E-Mail: info@simeg-international.com