

PHILIPPINE LEAGUE AGAINST EPILEPSY, INC.

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MEMBERSHIP / APPLICATION FORM

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Salutation (Dr., Mr., Mrs., Ms., Prof.) _____ **Profession:** _____

Specialty : _____ **Subspecialty** _____

Designation (Academic/medical degrees) _____

Predominant Professional Activity _____

Name of Institution: _____

Address of Institution: _____

Postal Code: _____ **Town / City:** _____ **Province:** _____

Academic Rank/Position: _____

Telephone: _____ **Fax:** _____ **E-mail:** _____

Clinic Address/Hours/Telephone: _____

Home Address: _____

Home Telephone No: _____ **Mobile Phone No.** _____

Educational Background : (College / Postgraduate - Inclusive Years)

Residency/ Specialty Training:

Post Residency / Subspecialty Training:

Hobbies: _____

What Committees / Services of the PLAE would you like to get involved with?

() Advocacy

() Health Care Delivery

() Continuing Medical Education

() Lay Education

() Fund Raising

() Research

