

APPLICATION OF MEMBERSHIP
to the European Restless Legs Syndrome Study Group e.V.

Please fill out in type!!

Name:	_____		
Title (e.g. Prof, MD):	_____	Mr. <input type="checkbox"/>	Mrs. <input type="checkbox"/>
Hospital/Dept.:	_____ _____		
Street:	_____		
ZIP-Code:	_____	Town:	_____
Country:	_____	State:	_____
Phone:	(++_____-)	_____	- _____
Fax:	(++_____-)	_____	- _____
E-mail:	_____		

Herewith I declare that I want to become a member of the EURLSSG e.V. according to the bylaws.

Date: _____ **Signature:** _____

Return to:

Marco Zucconi, president
EURLSSG - Office
c/o Sabine Panier
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++49-8261-759-114

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