The Maltese Association of Specialists in Psychiatry

APPLICATION FORM

NAME ______________________ SURNAME ________________
TITLE _______________________
ADDRESS ____
____
Country _______________ Post Code _____________
Telephone numbers: Home ________________
Clinic ________________
Hospital ______________
E-mail:____________________

CATEGORY OF MEMBERSHIP BEING APPLIED FOR:
(tick as appropriate)
(A) FULL ☐
(B) HONORARY ☐
(C) ASSOCIATE ☐

PRESENT APPOINTMENT ___________________________________

QUALIFICATION	Date of qualification	Body granting qualification
_________________	________________	______________________
_________________	________________	______________________
_________________	________________	______________________

Proposed by: __________________________ Signature ______________

Signature of Applicant __________________ Date __________________

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Scrutinizers Dr. J. Saliba
Dr. J. Spiteri

Date of acceptance ____________________