APMA NEW MEMBER FORM

*Required fields

PERSONAL INFORMATION

Full name*:	
Date of birth*:	Nationality:
Address*:	
Zip Code*:	Location*:
Personal email*:	
Phone number *:	Phone number 2:
Tax Identification Number (personal)*:	

ASSOCIAÇÃO PORTUGUESA DE MEDICINA DA ADICÇÃO - A.P.M.A.

PROFESSIONAL INFORMATION

Occupation*:Physician ☐	Medical Student ☐ Other	Specify:_____
Clinical/Professional Name:		Professional Certificate number*:
Specialty(s):		
Expertise(s):		
Workplace:		
Professional email:		
Workplace Phone number:		Workplace Phone number 2:

DATA FOR APMA BILLING PROCESSING / APMA MEMBERSHIP RECEIPT

Tax Identification Number:	
Social designation:	
Tax address:	
Zip code:	Location:
E-mail address:	Phone number:

Date* _____/ _____/ _____ Signature*: _____

TO BE FILLED BY APMA

Proposal received date:	Board meeting approval:	Member number:

PROPOSING MEMBER

Name:	Member number:	Signature: