



Membership Application

Please print in capital letters.

First name _____ Last name _____

Address _____

Postal Code _____ City _____

Country _____

Phone _____ Fax _____

E-mail Address _____

Hospital or Business Name _____

Business Address _____

Please use this address for any ECET communication: Personal Business

Full Membership

I am a: Stoma Nurse Wound Care Specialist Continence Nurse Doctor
 Other _____

I am applying for the following membership:

One-year membership (€20 fee)

Two-year membership (€35 fee)

Associate Membership

I am an: Industry Professional Other: _____

I am applying for the following membership:

One-year membership (€120 fee)

Two-year membership (€200 fee)

Please pay your membership fee electronically:

EUROPEAN COUNCIL OF ENTEROSTOMATHERAPY

No.630 – 5002303 – 72

IBAN BE 38 630 500 2303 72

Swift Code (BiC Code) BBRUBEBB

ING Belgium

1180 Bruxelles, Belquim

IMPORTANT: Membership renewals are due by May 15th

Date _____ Signature _____

E-mail or Fax completed application: Email G.Wiesinger@salk.at / Fax 0043 662 4482 54018