

# IMO Membership Application Form for Consultants



IRISH MEDICAL  
ORGANISATION  
Coardhumann Dochtúirí na hÉireann

*Applicants must hold qualifications acceptable for registration with the Medical Council of Ireland.*

## Personal Details:

Surname: \_\_\_\_\_

Forename: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Male       Female

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Work Address(es): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Please tick Address IMO correspond to:

Home       Work

Work Telephone: \_\_\_\_\_

Mobile No: \_\_\_\_\_

Email Address: \_\_\_\_\_

University Attended: \_\_\_\_\_

Year of Graduation: \_\_\_\_\_

Category of Registration with Medical Council number: \_\_\_\_\_

Registration No: \_\_\_\_\_

## Please tick appropriate box where applicable:

- Newly Appointed Consultant
- Consultant appointed Pre 2012
- Locum
- Dentist
- Academics
- Temporary

## Speciality:

- Anaesthesia
- Emergency Medicine
- Medicine
- Obstetrics/Gynaecology
- Orthodontics
- Pathology
- Paedriatics
- Psychiatry
- Radiology
- Surgery
- Other

## Subspeciality:

\_\_\_\_\_  
\_\_\_\_\_

I consent to IMO Financial Services contacting me regarding the financial products and services available to me as a members of the IMO which may be of interest to me. If you wish us to forward your contact details to IMOFS and be contacted by IMOFS in writing, by email, by landline and mobile phone, SMS text and fax electronic, please tick this box:

# SEPA Direct Debit Mandate



IRISH MEDICAL  
ORGANISATION  
Ceardchumann Dochtuifil na hEireann

Unique Mandate Reference

\* Unique Mandate Reference (UMR) – (For official use only)

By signing this mandate form, you authorise (A) the Irish Medical Organisation to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from the Irish Medical Organisation.

As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank.

A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

Please complete all the fields marked \*

Creditor's name	I	R	I	S	H		M	E	D	I	C	A	L							
	O	R	G	A	N	I	S	A	T	I	O	N								
Creditor identifier	I	E	7	0	S	D	D	3	0	0	0	5	4							
Creditor address	1	0		F	I	T	Z	W	I	L	L	I	A	M		P	L	A	C	E
City	D	U	B	L	I	N		2												
Post Code																				
Country	I	R	E	L	A	N	D													

Type of payment  Recurrent payment  or One-off payment

Debtor Name\*

Debtor Address\*   
City\*   
Post Code\*   
Country\*

Debtor account number IBAN\*   
Debtor bank identifier code BIC\*   
Date of signature\*

Please sign here\*

Please return this mandate to the Creditor

## For Information Purposes Only:

Recurring Payment Schedule: (Please tick as appropriate) Monthly  Annual