

**I.A.M.R.A.**  
**INTERNATIONAL ASSOCIATION OF MEDICAL REGULATORY AUTHORITIES**  
**MEMBERSHIP APPLICATION FORM**  
*PLEASE TYPE OR PRINT*

**Please complete the information below:**

\_\_\_\_\_  
Name of Organization:

\_\_\_\_\_  
Department or Division (if appropriate):

\_\_\_\_\_  
Street Address or Post Office Box/Contact:

\_\_\_\_\_  
City:

\_\_\_\_\_  
State or Province:

\_\_\_\_\_  
Country:

\_\_\_\_\_  
Zip or Postal Code:

\_\_\_\_\_  
Name of Chief Executive Officer (CEO):

\_\_\_\_\_  
Title of CEO:

\_\_\_\_\_  
Phone:

\_\_\_\_\_  
Fax:

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

\_\_\_\_\_  
Organization Web Site:

**Person to whom all communications from the IAMRA Secretariat should be sent (if different from above):**

\_\_\_\_\_  
Name:

\_\_\_\_\_  
Title:

\_\_\_\_\_  
Phone:

\_\_\_\_\_  
Fax:

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

