



Faculty of Pharmaceutical Medicine of the Royal Colleges of Physicians of the United Kingdom

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APPLICATION FOR AFFILIATE MEMBERSHIP

Please complete all sections and submit with a copy
of your current curriculum vitae.

Date received:

Recommendation of
Education Committee:

Acknowledgement
sent:

PERSONAL DETAILS			
Title	Surname	First Name	Other Names
Permanent Address		Address for Correspondence (if different from permanent address)	
City/Town		City/Town	
Country		Country	
Postal Code		Postal Code	
Telephone Number (include country and area code)		Telephone Number (include country and area code)	
Fax Number		Fax Number	
Email Address			
Gender Male <input type="radio"/> Female <input type="radio"/>		Date of Birth (dd/mm/yy)	
Country of Citizenship			
REGISTRATION			
General Medical Council (GMC) UK Registration number			
Date of full registration (dd/mm/yy)			
Other registration (please indicate country)			
Date of other registration (dd/mm/yy)			
Are you a member of the Royal College of Physicians (UK)? Yes <input type="checkbox"/> No <input type="checkbox"/>			
QUALIFICATIONS			
UK Diploma in Pharmaceutical Medicine (please tick)		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date awarded (dd/mm/yy)			
Have you qualified as a Clinical Pharmacologist? (please tick)		Yes <input type="checkbox"/>	No <input type="checkbox"/>

