



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

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Registered Charity No 1130573 & Company No 6870644

Date received:

APPLICATION FOR AFFILIATE MEMBERSHIP

Affiliate membership is open to physicians who work in or are able to demonstrate a current professional interest and connection with pharmaceutical medicine. Applicants must possess a medical qualification listed in the WHO Directory and current full registration with the GMC or the relevant professional body in the country in which they are practising or where they were awarded their primary medical qualification.

Please note that becoming a member of the Faculty may create a prescribed connection to the Faculty for revalidation now or in the future. If you have any questions about this please contact the Faculty.

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

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	Female	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)			
QUALIFICATIONS			
UK Diploma in Pharmaceutical Medicine (please tick)	Yes	No	
Date awarded (dd/mm/yy)			
Other degrees, diplomas, certificates, etc.	Date awarded (dd/mm/yy)	Issuing body	

EMPLOYMENT You must attach a current curriculum vitae with details of your full employment history

Date started in Pharmaceutical Medicine (dd/mm/yy)	
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CURRENT EMPLOYMENT

Post currently held	Employer
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Full or part time	Date commenced (dd/mm/yy)
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PREVIOUS EMPLOYMENT

Employer	Title of post	Full or part time	Date commenced (dd/mm/yy)

Please state below your current professional interest and connection with pharmaceutical medicine

Please let us know why you are applying for Affiliate membership

DECLARATION

I would like to apply for Affiliate membership of the Faculty as indicated, and declare that the information given on this form is true to the best of my belief and knowledge. I hereby consent to being admitted to membership of the Faculty and faithfully promise to abide by the Articles of Association of the Faculty and the Laws, Bye-Laws, Statutes and Regulations of the Colleges as they apply to members of the Faculty of Pharmaceutical Medicine.

Signature	Date (dd/mm/yy)
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Completed applications should be sent to the Faculty at the address overleaf

Data protection
The Data Protection Act requires organisations or agencies collecting personal data on individuals to gain their consent before collecting, storing, publishing or analysing their data. By completing and signing this application for membership of the Faculty of Pharmaceutical Medicine you are giving your consent for your data to be stored and used by the Faculty. All data will be treated with the strictest confidence and will only be used for legitimate Faculty purposes. Our full data protection statement is available on the Faculty website.