**ESID PAYMENT FORM**

If you wish to pay by Bank Transfer please complete this form and email or fax back to the address above. Please ensure you complete this form clearly and accurately to avoid any mistake in completing your payment.

**Title (please check one box only): Prof. Dr. Mr. Mrs. Ms.**

**Last Name** **First Name**

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**ESID MEMBERSHIP CATEGORIES**



ESID Regular membership 2018/2019 EUR 125

ESID Junior membership 2018/2019\* EUR 75

ESID Reduced membership from certain countries 2018/2019\*\* EUR 75

 LASID, ASID or APSID membership 2018/2019\*\*\* EUR 75

CIS membership 2018/2019\*\*\*\*EUR 75

*\** Reduced fee for under 35, valid ID or passport copy required *\*\* Please refer to ESID Website at* [*www.esid.org*](http://esid.org/Membership2/Join-ESID)  *for more information*

 \*\*\* Valid LASID, ASID or APSID certificate of membership or other proof required *\*\*\*\* Valid CIS certificate of membership or other proof required*

**PAYMENT**

**Bank transfer:**

Please ensure that **“ESID Membership fee”** and the name of the member are clearly marked on the transfer.

If payment is for more than one person or by a company, please make sure all names are indicated.

**Please send a copy of this form together with a copy of the bank transfer to the address above.**

Checking account number: ABN AMRO; IBAN: NL17ABNA0438813995 (ESID Membership); SWIFT/BIC: ABNANL2A; Nieuwstraat; Postbus 201; 5201 AE S-HERTOGENBOSCH;The Netherlands

Make sure to indicate clearly the Bank, Branch and date of the transfer.

*Bank charges are the responsibility of the payee and should be paid at source in addition to the membership fees.*

**Address of the Society:** European Society for Immunodeficiencies (ESID), (Europese Vereniging voor Immunodeficienties), KvK 40448576, Mijnbouwstraat 23, Delft, The Netherlands

**Signature: Date (dd/mm/yyyy):**