***ESPID* Membership Trainee Declaration Form**

Full Name: Address:

Tel: E-mail:

**For completion by the Head of Department**

I confirm the above particulars to be correct

Department: Institution: Date: Name:

Signature:

*Please make sure that the form is signed by your Head of Department and dated.*

If you have indicated that you qualify for trainee membership with ESPID, please fill in this form and return by **e-mail** to the following address: admin@espid.org

**I confirm that I am training in Paediatric Infectious Diseases or in Paediatrics**

Signature:

Date:

# Please note - trainee membership is valid for 3 years only. Thereafter you will automatically become a full *ESPID* Member.