



MEMBERSHIP REGISTRATION FORM

Please return the completed form to: **ANA ASLAN INTERNATIONAL Foundation,**

E-mail: office@brainaging.ro, Fax: +40 (0) 21 312 46 96

Ms. Mr. Prof. Dr.

Surname: _____

First Name _____

Birth date (dd.mm.yy) _____

Institution/Department _____

Street, No. _____

Postal Code, City _____

Country _____

Phone / Fax / E-mail _____

Date / Signature _____

AMOUNT IN EURO/YEAR

- 200 Full Member + Brain Aging Journal included
 100 Retired + Brain Aging Journal included
 100 Member-in-Training + Brain Aging Journal included
 50 Student + Brain Aging Journal included

METHOD OF PAYMENT:

Bank transfer in Euro:

Beneficiary: **FUNDATIA ANA ASLAN INTERNATIONAL**

RO40 BSEA 0409 0000 0000 1100

EMPORIKI BANK; Carol Branch, 66 Carol Blvd., Bucharest

Swift code (BIC): BSEAROBU

Please indicate your professional background (multiple entries possible)

Academic degree(s)

MD PhD other: _____

Specialties in clinical medicine

- Psychiatry
 Neurology
 Geriatrics
 General practice/primary care medicine
 other: _____

Non-clinical disciplines

- biomedical sciences (including biochemistry, biology, genetics, microbiology, etc.)
 medical care
 pharmacology
 pharmacy
 public health medicine
 other: _____

HEAD OFFICE

ANA ASLAN INTERNATIONAL Foundation

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“ANA ASLAN” MEMORY CLINIC

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Aging Prevention

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