The British Association of
Audiovestibular Physicians

BAAP
Medical Specialists in
Hearing and Balance

MEMBERSHIP APPLICATION / REGISTRATION FORM

FULL NAME: ……………………………………………….

TITLE: ………………………………………

MAIN HOSPITAL ADDRESS:
……………………………………………..
……………………………………………..
……………………………………………..
……………………………………………..

POSTAL CODE:…………………………

QUALIFICATIONS:
………………………………………..
………..…………………………

ROYAL COLLEGE NO:…………..

DOB: ……………………………….

DATE APPOINTED: ……………….

HOME ADDRESS:
……………………………………………
……………………………………………….
……………………………………………….

POSTAL CODE:…………………………

GRADE: ……………………………..

GENDER: **MALE FEMALE**

TELEPHONE NUMBERS:

Home:…………………………………….

Work:……………………………………..

Mobile: ……………………………………

EMAIL ADDRESSES:

Permanent:…………………………..

Work:…………………………………

Are you already a member of IAPA? ***Yes No***
(The International Association of Physicians in Audiology)

Are you a member of any Royal College? ***Yes No***
If yes, please state which College, your membership category, and membership number

…………………………………………………………………………………………………….

*Please indicate with a tick or star in the margin the postal and email addresses to which you would like your correspondence to be sent. Most communications with BAAP are now by email.

PLEASE ENCLOSE A (SHORT) CV WITH THIS REGISTRATION FORM, together with the name and address of a referee or sponsor. The completed form should be returned to the Hon. Secretary or by email to the Administrative Secretary.

THE INVOICE FOR YOUR **MEMBERSHIP SUBSCRIPTION** WILL BE SENT SEPARATELY BY THE HON. TREASURER.

Please remember it is YOUR RESPONSIBILITY to keep the BAAP secretariat advised of any changes in addresses etc.

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