

**APPLICATION FORM  
MEDICAL STATISTICS**

**PERSONAL DATA**

Family name: \_\_\_\_\_

First names: \_\_\_\_\_ Male/Female

**CORRESPONDENCE ADDRESS**

Address: \_\_\_\_\_

\_\_\_\_\_

Postal Code: \_\_\_\_\_

City: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**PROFESSIONAL INFORMATION**

Current Position: \_\_\_\_\_

Organization: \_\_\_\_\_

Department: \_\_\_\_\_

Member SHARE/GUIDE/BCN/Kolff-Institute: Yes/No: Member of \_\_\_\_\_

**BILLING ADDRESS (you need not fill this in when member as mentioned above)**

Organization: \_\_\_\_\_

Department: \_\_\_\_\_

Attn.: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Postal Code: \_\_\_\_\_

City: \_\_\_\_\_

**Projectcode:** \_\_\_\_\_

**Signature Business Manager:**

Date: |\_|\_|-|\_|\_|-|\_|\_|\_|\_|

Signature: \_\_\_\_\_

**SIGNATURE APPLICANT**

Place: \_\_\_\_\_

Date: |\_|\_|-|\_|\_|-|\_|\_|\_|\_|

Signature: \_\_\_\_\_

Please send to: Aukje van der Zee, Secretariat Epidemiology, UMCG, Dept. Epidemiology (FA40), Triadegebouw, Entrance 24, E3.06, P.O. Box 30.001, 9700 RB Groningen