Membership Application Form

DETAILS OF THE ORGANISATION APPLYING FOR MEMBERSHIP

Full name of the organisation _____

Short name of the organisation _____

Street name _____

Postal code _____ Town _____

Country _____

Website _____

VAT-number _____

If billing address is different from postal address above, please add it here.

Street name _____

Postal code _____ Town _____

Country _____

Application as

- ☐ Patient organisation, citizen/family/carer association
- ☐ Health care provider (GP, hospital, medical center)
- ☐ Health care provider association (*)
- ☐ Health professional association (*)
- ☐ Social care provider association (*)
- ☐ Public health, care, eHealth or research decision-making authorities
- ☐ Third-party health and care payer, health insurance organisation, commissioner (*)
- ☐ Clinical and health informatics research and educational organisation (*)
- ☐ Electronic health (eHealth) competence center (*)
- ☐ EHR system or applications vendor (*)
- ☐ Medical device vendor (*)
- ☐ Pharma, bio-tech (*)
- ☐ Health data broker or analytics company (*)
- ☐ Standards development organisation (*)
- ☐ Industrial association of health ICT products/services (*)
- ☐ Other: _____

For a definition of member categories, please consult our website.

(*) Membership fee is mandatory. Indications of this fee are mentioned on our website. Upon evaluation of your application, we will contact you with regards to your definite membership fee, taking into consideration the size of your association/ company, turnover, number of employees etc.

DETAILS OF THE MAIN CONTACT AND REPRESENTATIVE IN YOUR ORGANISATION

Name ______________________________

Title ______________________________

Phone ______________________________

Email ______________________________

- ☐ I apply for a two-year membership
- ☐ I have read and accepted the i~HD Articles of Association available upon request and the i~HD Data Protection Transparency and Privacy Notice available on the website.
- ☐ I confirm that I have the power to formally represent my company/organisation.
- ☐ I agree to be informed by email of initiatives taken by i~HD, and to receive their newsletter (maximum 4 newsletters a year).

Date: ______________ Signature

DETAILS OF OTHER INTERESTED PERSONS IN YOUR ORGANISATION

Name ______________________________

Title ______________________________

Email ______________________________

☐ I agree to be informed by email of initiatives taken by i~HD, and to receive their newsletter (maximum 4 newsletters a year).

Date

Signature

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Title ______________________________

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Signature

To be returned by email or post to:

The European Institute for Innovation Through Health Data
c/o University Hospital Gent - Unit of Medical Informatics and Statistics
Entrance 42 - Building K3 – 5th floor
Corneel Heymanslaan 10 - 9000 Gent (Belgium)

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