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| **EAACI POC Membership Application Form Contact Information for Patient Organization** | | | |
| **Organization Name** (English) | |  | |
| **Organization Name** (Your language – include short form/ acronym) | |  | |
| **Postal Address** (Include country) | |  | |
| **Telephone Number (Include country code)** | |  | |
| **Fax Number** (Include country code) | |  | |
| **Organization’s Email Address** | |  | |
| **Website** | |  | |
| **About the Organization** | | | |
| **Year Organization Established** | |  | |
| **Legal Status of the Organisation** | |  | |
| **Number of Paid Staff** | |  | |
| **Number of Volunteers** | |  | |
| **Number of Members (if applicable)** | |  | |
| **Number of people your organization represents, e.g. % population with food allergy** | |  | |
| **Annual Revenue** (EURO)**.** Specify main sources of revenue (membership, donations, grants, etc.) | | | |
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| **Organizational Profile** (Describe (up to 100 words) the main areas of focus of your organization, e.g. anaphylaxis, food allergy, allergic rhinitis, asthma.) | | | |
| **Motivation for Participation** (Describe (up to 100 words) the reason why you want to join the EAACI POC and how you can contribute.) | | | |
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| **Proposed POC Representative** (This should be approved by the head of your organization and have decision competences.) | | | |
|  | **Proposed Alliance Representative** | | **Second Point of Contact** |
| **Name & Title/Position** |  | |  |
| **Email Address** |  | |  |
| **Telephone Number** |  | |  |
| **Mobile Phone Number** |  | |  |
|  |  | |  |
| **Submitted by:** | | | Date: |