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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** |  |  |
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| **Submitted by:** | Date:  |