



Irish Association of Sterile Services Managers (I.A.S.S.M.)

Membership Application Form

DATE: _____

NAME: _____

ADDRESS (WORK):

E-MAIL: _____

TELEPHONE: _____ **FAX:** _____

POSITION: _____ **DEPARTMENT:** _____

ADDRESS FOR CORRESPONDENCE: _____

FULL MEMBERSHIP (€30):

ASSOCIATE MEMBERSHIP (€15):

PLEASE RETURN APPLICATION FORM TO:
Patricia Doheny CSSD St Luke's Hospital Kilkenny

OFFICIAL USE ONLY

MEMBERSHIP APPROVED: YES NO

APPROVAL DATE: _____

APPROVED BY: _____