HERITAGE HOUSE, DUNDRUM OFFICE PARK, DUBLIN 14.
TELEPHONE: 298 9123 FAX: 298 9395

Application Form for Associate Membership

Forename(s) ______________________ **Surname** _______________________

Preferred Mailing Address ____

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Email ______________________________________ Telephone No ____________________

Mobile No __________________________________ Date of Birth ____/_____/________

Country of Residence _______________________ Male ___ Female ___ (Tick as appropriate)

Current hospital or mental health service employer _______________________________________

Please enter your Speciality ____

Irish Medical or Dental Council Reg No. __________________ (current or most recent)

Other Medical or Dental Council Reg No., if any _______________

Declaration of Eligibility for Associate Membership: (Tick as appropriate)

I have commenced in or completed the final two years of my specialist training; ☐

or

I have received a Certificate of Satisfactory Completion of Specialist Training (CSCST) from an Irish Postgraduate Training Body. ☐

Name of Postgraduate Training Body ________________________________

Date of CSCST ____/____/________ (or projected date if not yet received)

Please return your completed form by email to s.nutley@ihca.ie, by fax to (01) 298 9395 or by post to IHCA, Heritage House, Dundrum Office Park, Dundrum, Dublin 14