



CERTIFICATE FOR ECCOMAS @#U MEMBERSHIP

.....
ECCM-ECFD 201
.....8 , yM
.....Ju 1 - , 201

Date:

Participant Full Name:

Name of ECCOMAS or IACM Association:

.....

Registration Ref. ID:

This is to certify that is a
member of the ECCOMAS / IACM affiliated Association

.....

Association President Signature

Name of President:

Please send this form by fax (34 93 205 83 47) to the secretariat, including invoice information.

First Name:Family Name

Organization: Department:

VAT(*)..... Address:Postal Code:.....

City: State Province: Country:

Phone: Fax: Email:

(*) VAT Number is mandatory for EU countries – Passport or ID Card in case of natural person

FEES (Price in Euro):

		<i>Payment before March 15, 2018</i>	<i>Payment before April 1, 2018</i>	<i>Payment after April 1, 2018</i>
	IACM/ECCOMAS Member (Including Congress Banquet)	645 €	695 €	740 €
	IACM/ECCOMAS Member (Not Including Congress Banquet)	550 €	600 €	645 €
	Accompanying Persons Program (Includes Welcome Reception and Congress Banquet)	150 €	150 €	150 €
	Total Payment:			

PAYMENT METHODS:

I have ordered a bank transfer to:

Bank: CAIXABANK - C/TRIAS GIRO, 11-13 (08034) Barcelona - Spain
 IBAN: ES24 2100 1801 1202 0005 7173
 SWIFT CODE: CAIXESBBXXX Account Holder: CIMNE
Please attach copy of the bank transfer to this form.

I would like to pay the above marked amount by credit card.

Visa American Express Master Card

Card number: _____

Expiry date: _____

CCV: (last 3 digits on the back of the credit card, 4 digits if AMEX) _____

Cardholder's name: _____

Date: _____

Authorized signature: _____