

Membership Subscription Form
Saudi Society for Family and Community Medicine

NAME:.....

MALE:

FEMALE:

NATIONALITY:..... AGE:.....

AGE:.....

Work Place:..... Job Title:.....

Last scientific qualification:.....

Specialization.....

Address: P.O. Box() City() Postal code()

Email:

Mobile:.....

Housing Phone:.....Work Phone:.....

Membership No

Renew Subscription

New subscription

Type of Membership:

*I would like to be a working Member:for from(20..) to(20 ..)

1 year(150SR) 2YEARS(300SR) 5YEARS(500SR)

I would like to be a Associate Member:for from(20..) to(20 ..)

1 year(50SR) 2YEARS(100SR) 5YEARS(175SR)

Working Member: Anyone who holds a university qualification in the field of health and works Doctor within the Kingdom or non-doctor of all nationalities.

Associate Member: All those who do not meet the conditions of working membership.

Account Number of Saudi Society for Family and Community Medicine :

٣٠١٦٠٨٠١٠٠٢٩٩٠٤ **Al Rajhi Bank –AlAqrabyah Branch 301**

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