Membership form	Year
Name:	Surname:
Company:	Local Distributor:
Tel Nos: Work Home	Email:
Mobile	
Postal Address: (Wherever you wish to receive mail)	
Qualifications	Do you wish to be included in the Health Centre Roster?
Pharmacist: Yes No	Yes No
Other (Please specify):	Would you like your details to be included on the AMR Website?  Yes No
Manager's Name:	Manager's Surname:
Manager's Mobile Number:	Manager's email:
For Office use only	
Membership number:	Paid:
Kindly fill in Section A and Sec	ction B as appropriate
<b>Section A- Renewing Members</b>	ship
I hereby re-confirm my commitments Representatives at Mater Dei Hospita	to abide by the 'Procedure for Visits by Medical al'.
Signature	
	Dale
Section B- New Member	
I hereby confirm my commitments to	abide by the 'Procedure for Visits by Medical
-	al'. (Kindly attach signed procedure with this form. In

Date

Signature