****

**EHRS Membership Application**

*Please complete in block letters or in type script*

Surname:

Forename(s):

Title(s): [ ] Prof [ ] Dr [ ] Mr [ ] Mrs [ ] Miss [ ] Ms [ ] Other *(please specify)*

Present position:

Institution/Organization:

Department/Division:

Address:

Country:

Telephone:

Email:

Address for correspondence *(if different from above)*:

Date of birth (DD/MM/YYYY):

*(if under 30 years, please include photocopy of passport or other official document)*

Current research interests:

Details of up to 5 recent/relevant papers:

1.

2.

3.

4.

5.

**General Data Protection Regulation (GDPR) Consent Form**

By signing this form, you are confirming that you are consenting to EHRS contacting you by email, post and/or phone and holding and processing your personal data for the purposes listed below [details on how we use your data can be found in our “Privacy Policy” at the EHRS website (<https://www.ehrs.org.uk/privacy-policy/>)].

Personal data is any information that identifies you as an individual, including name, surname, title, affiliation, contact address, Email, telephone number, scientific area, qualifications.

Your data will not be shared with any third parties without your consent.

You can withdraw or change your consent and correct or delete any personal information at any time by contacting the President of the EHRS by email. Processing will not affect any data that has already been processed prior to this point.

I give my consent to the European Histamine Research Society (EHRS) to (*please tick the relevant boxes below*):

🞏 store, process and use my data in paper and electronic formats to perform necessary functions for the smooth running of the Society, including maintaining records and the membership list;

🞏 keep me informed about news, newsletters, meetings, events and activities, regarding both the EHRS and other organizations that are aligned to the EHRS objectives;

🞏 compile statistics and conduct surveys and research for internal and statutory reporting purposes (the data will be anonymised);

🞏 use any images, photos or video footage taken at the Society’s meetings, events or activities and include me, for the EHRS printed and online publications and publicity-related purposes, including leaflets, the EHRS website and social media sites.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(City, Country) (Date, DD/MM/YYYY) (Signature)*

**Proposer**\*

I, being a member of the EHRS, do, from my personal knowledge, recommend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(name of the candidate)* for membership of the EHRS.

Surname:

Forenames:

Address:

Email:

Date:

Signature:

**Seconder\***

I, being a member of the EHRS, do, from my personal knowledge, recommend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(name of the candidate)* for membership of the EHRS.

Surname:

Forenames:

Address:

Email:

Date:

Signature:

Please send the completed application form *(preferably by Email)* to:

Professor Katerina Tiligada

Department of Pharmacology
Medical School
National and Kapodistrian University of Athens
M. Asias 75
11527 Athens

GREECE

Tel:(+30) 2107462575

Email: EHRSPresident [at] med.uoa.gr

\**If you do not know a member of the Society, please contact the President directly at* EHRSPresident [at] med.uoa.gr