

MEMBERSHIP FORM



International Federation of Professional Managers

PERSONAL DATA

Mr./Ms./Mrs./Miss/Dr. Last Name :
First Name : Middle Name : Suffix :
Gender : Male Female Date Of Birth :
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EDUCATION & PROFESSIONAL INFORMATION

- **BACHELOR'S DEGREE** Year :
Course :
University :
- **MASTERAL** • **DOCTORAL** Year :
Course :
University :
- **OTHER:** Year :
University :
License No. : Year :

DATA PRIVACY

Upon signing this form you are agreeing that the personal data obtained from the registration form entered and stored within the Institute's authorized information and communications system and will only be accessed by the IFPM authorized personnel. Furthermore, the information collected and stored in this form shall only be used for the following purposes:

- Announcements / promotions of events, programs, courses and other activities offered / organized by the Institute and its partners;
- Activities pertaining to establishing relations with participants/members/alumni;
- IFPM has the right to share your information to our related affiliate companies, institutions, and or subsidiaries;
- IFPM shall not disclose the participants/members/alumni personal information without their consent and shall retain this information over a period of ten years for effective implementation, research analytics, and management.

ACCEPTANCE OF SUBSCRIPTION

I declare that all of the information contained in this application is true and correct and I agree to provide any supporting documentation requested by the Institute. If accepted, I agree to abide by the International Federation of Professional Managers' Code of Professional Conduct and Continuing Professional Education requirements. I understand that I must renew my subscription annually to enjoy the services provided by the Institute including eligibility privileges and retention of professional designation.

Signature _____

Date: _____

CONTACT INFORMATION

HOME MAILING ADDRESS

Home / Bldg. No., Street :
City :
Province : Postal Code :
Phone Number :
Mobile Number :
Personal E-mail Address :

BUSINESS MAILING ADDRESS

Position:
Company Name:
Home / Bldg. No., Street :
City :
Province : Postal Code :
Phone Number :
Fax Number : (Country code/Area Code/City Code)
E-mail Address :

MEMBERSHIP TYPE

Affiliate Membership

Certified Membership (CHRP®)

OFFICIAL USE ONLY:

INVOICE NO: _____ INVOICE DATE: _____
OR NO: _____ DATE PAID: _____
DCR NO: _____ VERIFIED: _____

APPLICATION RECEIVED ON: _____

[] COMPLETED REQUIRED DOCUMENTS
[] APPROVED MEMBERSHIP NO.: _____
[] NOT APPROVED REASON: _____