Interdisziplinäre Gesellschaft für orthopädische/unfallchirurgische und allgemeine Schmerztherapie e. V.

International musculoskeletal pain society

Aims of the Society:

The aims of the society are research, diagnosis, treatment, prevention and education of pain triggered by functional and structural dysfunctions of the locomotor and postural system, as well as the secondarily induced reflex pain syndromes, in particular taking into account the somatization of mental disorders.

Membership Application

Surname:..... First name: .....

Title:..... Date of birth: .....

Address (work):

Street: ..... Postcode: ..... City: .....

Telephon:..... Fax: .....

E-mail:..... Homepage: .....

Address (privat):

Street: ..... Postcode: ..... City: .....

Telephon:..... Fax: .....

E-mail:..... Homepage: .....

Education and Degrees:

.....

Exam in: .....
(e.g. Medicine, Dentistry, Biology etc.)

Specialized Training:.....

Current Position: .....
(Practice, University, Hospital, field of activity)

Specialist field:..... since:.....

Additional qualifications/since:.....
(e.g.. chiropracitc, acupuncture, etc.)

Treatment procedures:.....

Training authorization: yes ☐ no ☐

If yes: Field ..... Duration: ..... month: .....

Membership fees
admission fee: € 25,00 annual fee: € 160,00

On application assistants undergoing professional training will be exempt from paying the membership fees according to §7 (1) of the statute. The exemption is valid for one calendar year. Proof of professional training status must be provided without request by 31 December for each year. Membership fees according to §7 (1) of the statute are due if proof of the professional training status has not been provided in time, or if the professional training has ended.

Membership of other societies: .....

.....

I declare that I am willing to write scientific publications. Furthermore I am also willing to give oral presentations.

yes ☐ no ☐

I consent that, according to the statute I have on hand, the admission fee and the annual fee will be direct debited from my bank account.

Bank details:

Bank: ..... in: .....

IBAN _____

BIC: _____

D E C L A R A T I O N O F C O N S E N T:

I consent to the listing of the details of my medical practice on the homepage of IGOST. The details will be included in the section "Arztsuche".

yes ☐ no ☐

I consent to the goals of **IGOST** and herewith apply for membership.

City Date Signatur and Seal

1. Guarantor 2. Guarnator
(All Members of IGOST are accepted as a guarantor)

Please send the application to:

IGOST – Office
Grüner-Turm-Str. 4-10

88212 Ravensburg

Fax number: ++49 751 – 3 555 9797