IMSN Membership Application

I wish to apply for membership of the Irish Medication Safety Network as:

Attending member ☐ Membership for Circulation* ☐ (please tick one)

(*usually the Head of Pharmacy Department or designate)

Name: .....

Job Title: .....

Contact Details

Address:

Phone: ..... e-mail: .....

Geographical Area: .....
(corresponding to old Health Board area)

Specialist Sector (e.g. Maternity, Psychiatry, Oncology, etc.): .....
(if applicable)

Head of Department? Yes ☐ No ☐ (please tick one)

Do you have a specific Medication Safety role within your hospital?

Yes ☐ No ☐ (please tick one)

If yes, please describe briefly

.....

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NOTE: Application for attending membership includes an undertaking to regularly attend meetings and participate in working groups for medication safety projects (guidelines development, etc.) If you are interested in any undertaking work in any particular medication safety projects, please specify:

Date of application: .....

Please e-mail completed application form to: enquiries@imsn.ie IMSN Rev 1 30/03/2016