World Federation for Hospital Sterilisation Sciences

Subscription to WFHSS for Individual Members

Family Name * _____

First Name* _____

Country of residence* _____

Contact Address* _____

Country* _____

Postal Code* _____

City* _____

Street* _____

Is there an Association for Reprocessing of Medical Devices in your country?

yes no

If yes, please explain your subscription as individual member:

_____

Please describe your main activities in connection with Reprocessing of Medical Devices:

_____

I agree with the content of the statutes (bylaws)*

The filled "Conflict of Interest Disclosure Declaration" is attached*

* Mandatory field

CONFLICT OF INTEREST

DISCLOSURE DECLARATION

(Individual Members)

The intent of the disclosure declaration is to allow wfhss individual members to disclose any real or apparent conflict of interest with respect to their activities in relation to the aims of the wfhss.

NAME: _____

COUNTRY: _____

I hereby declare that I do not have any <u>commercial</u> interests in connection with Reprocessing of Medical Devices (e.g. distribution of MDs).

Date: _____

Name (please print): _____

Signature: _____