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WORLD FEDERATION FOR
WFHSS
HOSPITAL STERILIZATION SCIENCES

Subscription to WFHSS for Individual Members

Family Name*

First Name*

Country of residence*

Contact Adress*

Country*

Postal Code*

City*

Street*

E-mail Adress*

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

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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 commercial interests in connection with Reprocessing of Medical Devices (e.g. distribution of MDs).

Date: _____

Name (please print): _____

Signature: _____