EuroMed Feminist Initiative
المبادرة النسوية الأورومتوسطية
Initiative Féministe EuroMed

MEMBERSHIP APPLICATION FORM

INFORMATION ABOUT YOUR ORGANISATION		
Name of the organisation:		
Vision and Mission:		
Main areas of work:		
Number of active members:	Locally/Nationally:	Regionally:
Date of Establishment:	E-mail/www:	Phone:
Current address:		
City:	State:	ZIP Code:
CONTACT PERSON INFORMATION		
Name of the Contact Person:		
City/State:	Tel:	Email:
Position:		
MOTIVATION FOR JOINING EUROMED FEMINIST INITIATIVE		
MEMBERSHIP FEE		
Minimum membership Fee 100 euro	x	
Ability to pay up to:	x	
ANNEXES		
1. Statutes	x	
2. Organizational Chart	x	
SIGNATURE		
☐ Our organization shares values of the Euromed Feminist Initiative IFE-EFI and agrees with its Platform.		
Name and signature of authorized person:		Date: