



IFE - EFI

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:	Email/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 IFE-EFI

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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:
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