

## GAAPP - Membership Form

Please complete the membership form to join as a new member with Global Allergy and Airways Patient Platform (GAAPP). If you require assistance completing this form, please contact GAAPP-Office +49 (0)171 761 6923 or [info@gaapp.org](mailto:info@gaapp.org).

Please note: Items marked with Asterix \* are compulsory All boxes are free text unless otherwise indicated.

*Organization Name	<input type="text"/>
*Year of establishment	<input type="text"/>
*Street Address	<input type="text"/>
*City, Country & Zip Code	<input type="text"/>
*Telephone	<input type="text"/>
Fax	<input type="text"/>
*Email	<input type="text"/>
*Website	<input type="text"/>
*Facebook page	<input type="text"/>
*Twitter	<input type="text"/>
Instagram	<input type="text"/>
YouTube	<input type="text"/>
*Nominated contact person	<input type="text"/>
*Nominated contact person's e-mail	<input type="text"/>
*Nominated contact person's number	<input type="text"/>
*Position at organization	<input type="text"/>

**Please note that GAAPP correspondence and communications will be sent to the nominated contact person via email or the organization postal address.**

Your organization is a:

- National Organization
- Regional Organization

More than one of the following may be selected.

Your organization is:

- Patient Organization for Allergy
- Patient Organization for Asthma
- Patient Organization for COPD
- Patient Organization for Atopic Dermatitis
- Medical Organization with at least one patient group (in allergy, asthma, COPD, or AD)

\* Please indicate if your organization is working in the field of:

- Respiratory (Asthma, COPD)
- Allergy
- Food Allergy
- Atopic Dermatitis
- Other: \_\_\_\_\_

Please provide an **overview** of your organization, including **services provided** and **patient demographics**.

Please give an **example of a project** you are currently working on or one you recently completed successfully.

Please read the following and check if they apply.

- Check if your organization has a separate bank account.
- Check if you have submitted your organization's Statutes.

## Consent

We give GAAPP permission to use the above organizational details as part of GAAPP's core business.

- Yes  
 No

We give GAAPP permission to register our organization as a Member.

- Yes  
 No

Name	<input type="text"/>
Signature	<input type="text"/>
Position	<input type="text"/>
Date	<input type="text"/>

Thank you for completing the membership form. Once complete, please e-mail it to Allie Bahn at [abahn@allergyasthmanetwork.org](mailto:abahn@allergyasthmanetwork.org) along with your organization's statutes.