



**Patient Representative Fellowship Application Form
EURORDIS Membership Meeting Bucharest
EMM 2019**

Please return this application form by e-mail to anja.helm@eurordis.org before January 15th, 2019.

1. Your contact details

Last name		First name	
e-mail		Telephone	
City		Country	

2. Your organisation

Name:

Member of Eurordis? () Yes () No

Disease(s) represented:

Country		Website	
Date of creation		Revenues 2017	
Nbr of members		Nbr of staff/volunteers	

3. Your profile

Are you? <i>Please tick</i>	Patient	<input type="checkbox"/>	Volunteer	<input type="checkbox"/>
	Parent of patient	<input type="checkbox"/>	Staff	<input type="checkbox"/>
Do you need to be accompanied by an enabler?		Yes ()	No ()	
If yes, please explain for which disability				
How long have you been active in the organisation?				
Do you represent your organisation in any National/ European Committee/Task Force/ Working Group? <i>Please specify</i>				
Are you already involved in EURORDIS activities as a volunteer (<i>for example ePAG Advocate</i>)				

What is your educational/professional background? (5 lines max.)

4. Your role in the patient organisation - Please explain

6. Please explain why you want to attend the Meeting?

6. English language skills:

Poor () Average () Good () Excellent ()

7. As one of the selected participants, I agree to:

Share my knowledge & experience with the patient organisation I represent

Be included in EURORDIS list of potential volunteers to act as a rare disease patient representative

Name:

Date: