Membership Application Form of Asian College of Psychosomatic Medicine

Date of Application:
Year: ____ Month: ____ Day: ____

1. **Name:**
    - Full Name: _____
2. **Date of Birth:**
   Year: ____ Month: ____ Day: ____
3. **Contact Information:**
    - **Home Address:**
        - Address: _____
        - Postal Code: _____
        - Phone: _____
        - FAX: _____
    - **Work Address:**
        - Organization Name: _____
        - Address: _____
        - Postal Code: _____
        - Phone: _____
        - Preferred Contact: ☐ Home ☐ Work
4. **Email:**
    - Email Address: _____

5. **Educational Background:**

- Final Academic Background:
  - Graduation (Completion) Year: _____
  - Degree: _____

6. **Professional Occupation:**

・Physician ・Psychologist ・Nurse ・Researcher ・Other (please specify:)

7. **Specialization (if possible):**

・Psychosomatic medicine ・Internal Medicine ・Psychiatrist ・Psychologist ・Other (please specify:)

8. **Membership in Other Societies:**

- Please circle applicable societies:
  - Japanese Society of Psychosomatic Medicine
  - Japanese Society of Psychosomatic Internal Medicine
  - International College of Psychosomatic Medicine (ICPM)
  - Asian College of Psychosomatic Society
  - Others: _____

9. **Recommendation by a Member:**

- Name of the Recommender: _____

Contact us: Asian College of Psychosomatic Society Office, Department of Psychosomatic Medicine, Graduate School of Medical Sciences, Kyushu University
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