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| KoNES Membership Application |
| **Applicant Information** |
| Title  | *(Dr, Prof, etc)* |
| First Name |  |
| Middle Name |  |
| Last Name |  |
| Gender |  | Date of Birth |  |
| E-mail |  |
| Mobile phone |  |
| **Affiliation information** |
| Affiliation |  |
| Address |  |
| City |  | State |  | Postal(Zip) code |  |
| Country |  |
| Type of practice  | *(Medical Doctor, Nurse, Radiologist, Engineer, business member, others)* |
| Profession  | *(Neurosurgery, Neuroradiology, Neurology, etc)* |
| Recommender Name |  |
| Applicant signature  |  |
| Date |  |
| Write this application form and send E-mail to kones@konesonline.or.krApplication process take few days and KoNES send to E-mail after processing.Help: +82(2)-22779-9560, kones@konesonline.or.kr |