



## National Center - Application Form: Expression of Interest

Please complete this form and all required documents (see checklist) per email to:  
Mark Stoutenberg: [MStoutenberg@med.miami.edu](mailto:MStoutenberg@med.miami.edu)  
and in cc to Lisa Kempster: [lisa.kempster@uniklinik-ulm.de](mailto:lisa.kempster@uniklinik-ulm.de)

### Applicant Contact Information

1. Country for the EIM® National Center:

\_\_\_\_\_

2. Corresponding person:

Mr.  Mrs.  Dr.  Prof.

First name: \_\_\_\_\_

Address: \_\_\_\_\_

Surname: \_\_\_\_\_

Postcode/town: \_\_\_\_\_

Profession: \_\_\_\_\_

Country: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone/Fax: \_\_\_\_\_

3. Possible Members in the European Initiative for Exercise in Medicine e.V. (EIEIM)

#### National Centers

Exercise is Medicine® National Centers (one from every European state) who support our mission to promote public health by enhancing participation in physical activity. Membership applications will be reviewed by (ACSM) and the board of EIEIM. Please find further details in the Launch document.

#### Supporting organizations

Supporting organizations are European Organizations which would like to support the European Initiative for Exercise in Medicine and make use of the benefits, including usage of the logo (additional contract required) and/or getting allowance on the congress fees. Supporting organization do not have a voting right.

4. Membership fee

After approval of the application for membership, the regular membership fee (**15 €/year**) is due. Payment will be executed by SEPA Bank collection. There is no separate application fee.

### Acknowledgement

By my signature I acknowledge the valid statutes of EIEIM as binding. I agree to the storage, transmission and processing of my personal data for purposes of the association, according to the regulations of the data protection act. The EIEIM statutes can be downloaded from our website: <http://exerciseismedicine.eu>

I hereby express my interest for membership in the **European Initiative for Exercise in Medicine (EIEIM)**. I have read the statutes and conditions and I understand the privileges and responsibilities of membership. I certify that the statements on this application are true.

Place: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_