Association des Malades des Vaisseaux du Foie

AMVF

MEMBERSHIP

and/or

DONATION

Surname :

Given name :

You are : ☐ **patient** ☐ **Closes relatives or other** ☐ **Medical professional**

Address : ……

City : …… Zip Code : …….. Country : ……..

Phone : …….. Email : ……..

Your contribution to AMVF :

☐ **I want to become a Member of AMVF, the yearly fee is 25€…….**

☐ **I want to make a Donation to AMVF (amount in €)…….**

Total in € :

☐ **I am sending a check attached to this form**

From to be returned by mail to : **Association des malades des vaisseaux du Foie(AMVF)**
Hôpital Beaujon – Service d'Hépatologie
100 boulevard du général Leclerc
92118 CLICHY Cedex
FRANCE

Date : Signature :