Association
des Malades
des Vaisseaux
du Foie
AMVF

MEMBERSHIP
and/or
DONATION

Surname :

Given name :

You are a : **Patient □** **Close relatives or other □** **Medical professional □**

Address: .....
.....

City : ..... **Zip Code :** ..... **Country** .....

Phone : .....

Email : .....

Your contribution to AMVF:

□ **I want to Become a Member of AMVF, my yearly fee is 25€** .....

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

Total in € : .....

Date : Signature :

Form to be returned by mail to :

Association des Malades des Vaisseaux du Foie (A.M.V.F.)
Hôpital BEAUJON – Service d'Hépatologie
100 boulevard du Général Leclerc
92118 CLICHY Cedex
FRANCE

Or by email to : **tresorier@amvf.asso.fr**

Could you confirm which way of payment you have selected?

□ **I am sending a check attached to this Form**

□ **I am making an online payment through the secured payment system proposed on our website www.amvf.asso.fr**