International Agency for the Prevention of Blindness
London School of Hygiene and Tropical Medicine
Keppel Street, London WC1E 7HT
United Kingdom

Tel: +44 (0)20 7958 8394
Fax: +44 (0)20 7958 8325
Email: communications@iapb.org
www.iapb.org

MEMBERSHIP APPLICATION FORM

(Non–Governmental Organisations (NGOs),
Ophthalmological Societies, Institutions, Hospitals, etc)

A. CONTACTS DETAILS

NAME OF THE ORGANISATION	
COUNTRY	
ADDRESS	
WEBSITE	
CONTACT EMAIL	

ORGANISATIONAL REPRESENTATIVE TO IAPBCOUNCIL OF MEMBERS *(Entitled to attend as Voting Member IAPB Council of Members Meetings and AGM)*	
Name	
Position	
Email	
Telephone	

KEY CONTACTS*(fill as appropriate)*	
ADVOCACY Name Position Email Telephone ☐*tick here if you do NOT want to receive key updates and information from IAPB*	**COMMUNICATION** Name Position Email Telephone ☐*tick here if you do NOT want to receive key updates and information from IAPB*
FINANCE Name Position Email Telephone ☐*tick here if you do NOT want to receive key updates and information from IAPB*	**FUNDRAISING** Name Position Email Telephone ☐*tick here if you do NOT want to receive key updates and information from IAPB*
PROGRAMMES Name Position Email Telephone ☐*tick here if you do NOT want to receive key updates and information from IAPB*	**OTHER** Name Position Email Telephone ☐*tick here if you do NOT want to receive key updates and information from IAPB*

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B. ABOUT YOUR ORGANISATION – the information in this section will enable us to compile a picture of the IAPB membership global footprint and impact to support our advocacy messages, and will provide the content for the online membership directory.

ORGANISATIONAL PROFILE *(add separate sheet if necessary)* *Describe the mission and objectives of your organization. (A, B members 300 words / C members 150 words)*

LIST COUNTRIES WHERE YOU HAVE PREVENTION OF BLINDNESS / EYE HEALTH PROGRAMMES*(add separate sheet if necessary)*

NO.	COUNTRY	NO.	COUNTRY	NO.	COUNTRY	NO.	COUNTRY
1.		5.		9.		13.	
2.		6.		10.		14.	
3.		7.		11.		15.	
4.		8.		12.		16.	

NATURE OF PROGRAMMES*(Check relevant boxes)*

☐ Advocacy ☐ Age-Related Macular Degeneration ☐ Cataract

☐ Childhood Blindness ☐ Community rehabilitation ☐ Diabetic Retinopathy

☐ Glaucoma ☐ Grant-giving ☐ Health Systems Strengthening

☐ Human Resource Development ☐ Low Vision ☐ Nutrition

☐ Onchocersiasis ☐ Refractive Errors ☐ School Eye Health

☐ Trachoma ☐ Any other (*please specify*) _____

ANNUAL BUDJECT EXPENDITURE FOR EYE HEALTH ACTIVITIES
Please let us know approximately your latest annual budget expenditure on eye health programmes in US$ _____

NUMBER OF SALARIED STAFF EMPLOYED WORLDWIDE _____

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C. REASONS FOR JOINING

Why does your organisation wish to join IAPB and how would you and your staff expect to engage?

MEMBERSHIP CATEGORY & ANNUAL FEES FOR 2015(annexed to 3% annual increase)

- ☐ Group A US$ 65,670
- ☐ Group B US$ 19,100
- ☐ Group C US$ 1,790

We will be happy to promote IAPB and participate in joint promotional and programme activities together with other members and partners. We also agree that IAPB has the right to use information in this application form on its website and promotional materials.

Signature:_____Date:_____

Name:_____Organisation: _____

Enclose supporting information:

- Latest Annual Report
- Partners (if any)