**Membership Application Form**

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| --- | --- |
| Your Name and Surname |  |
| Institutional Affiliation (if any) |  |
| Job Title |  |
| Previous experience or expertise in Metacognitively Oriented Treatments |  |
| Street Address |  |
| City |  |
| Postcode |  |
| Country |  |
| Email |  |
| Phone  |  |
| Sign |   |
| Date |  |
| Send to | postmaster@mot-is.org |