Dr. Rath Health Programs B.V. – Postbus 657 NL - 6400 AR Heerlen – Fax: 0031 - 457 111 119
E-Mail: beratertaetigkeit@rath.nl

MEMBERSHIP APPLICATION

to join the Dr. Rath Health Alliance

Personal details:

Surname, first name

House no., street | Town, post code

Country | Date of birth

Telephone | Fax

e-mail

I hereby apply to become a member of the Dr. Rath Health Alliance. I would like to become (please tick appropriate box):

☐ a passive member.
As a passive member I receive a discount on my own orders of dietary supplements and books. I am aware of the fact that I must be an active member in order to receive fees. At any time I can become an active member by completing the "Cellular Medicine Foundation Course".

☐ an active member.
I have completed the "Cellular Medicine Foundation Course" necessary to become an active member.

Membership is free of charge, and I can relinquish it at any time subject to a notice of 30 days to the end of a month, without citing reasons.

Mr./Mrs/Ms. ____________________

Membership number ____________________

(Signature of member)

has given me a detailed introduction to the bases and aims of the Dr. Rath Health Alliance. I have received a copy of the Dr. Rath Health Alliance guidelines, and am in agreement with them.

I agree that the member sponsoring me will receive information about my orders (order date and value). This will enable him/her to check his/her fee calculation.

Please transfer my own fees to the following account:

Bank | Sort code

Account number | BIC

IBAN

(Place, date, Applicant's signature)

1148/02-0308

Please accept that we can only process fully completed applications. In the case of any changes to your personal data, please send these to us as quickly as possible to ensure that we can calculate and pay your fees smoothly. Please retain a copy of this application plus guideline for your personal information.