



Membership Survey

1. Contact Details

First Name:

Last Name:

Address:

Country:

Tel:

Fax:

E-mail:

Cochrane Collaboration Affiliation:

YES

NO

If Yes, which entity? *Please specify:*

Center:

CRG:

MG:

Field:

Network:

2. I wish to be:

Active:

Please go to Section 3.

Kept informed of the activities:

End of the survey

3. Subgroups of interest *(for active members only)*

Please put a cross (X) in front of the Working Group (WG) corresponding to your choice:

- **Concepts and Methods Review:**
- **Review Design Group:**
- **Analysis Group:**
- **Fields/Conditions/Pathologies of interest :** *CNS, Diabetes, Elderly, Gastrointestinal, HIV, Musculoskeletal, Oncology/Palliative Care, Ophthalmology, Oral dental health, Psychiatry, Respiratory Diseases, Urology* - **Please specify:**
- **Workshops**

I am volunteer (as a speaker) to participate in workshops which will be organised either during the CC annual colloquium or at other occasions:

YES

NO