

Application Form Membership | Registration for Distance courses

Please complete form, print it out, and send via post to:

Zentrum für wesensgemäße Bienenhaltung / Centre for ecological Apiculture
Z.Hd. Di. Michael Thiele
Franzrasen 2
D-37242 Bad Sooden

Become A Member Now!

*Fields marked with asterisk are mandatory. They have to be filled for further processing of your registration.

<input type="checkbox"/> Yes, I want to become an official member of Save Bee Colonies / Natural Apitherapy Council / Club of Ecological Beekeepers. In this way I support research of the Centre for Ecological Apiculture and Centre for Natural Apitherapy. On top of that you are going to receive 50 % discount on distance courses. Registration fee is 699 €. I require the following membership type:
<input type="checkbox"/> 69 € individual rate p.a. for single persons, small scale beekeepers
<input type="checkbox"/> 269 € individual rate p.a. for professional beekeepers, medical doctors, naturopathic doctors
<input type="checkbox"/> 1.200 € organizational rate p.a. for organisations, associations

<input type="checkbox"/> Yes, as a member I want to register for the following distance courses.
<input type="checkbox"/> No. 19 title: Ecological Topbar Beekeeping tuitionfee 450 €
<input type="checkbox"/> No. _____ title _____ tuitionfee _____ €
<input type="checkbox"/> No. _____ title _____ tuitionfee _____ €
<input type="checkbox"/> No. _____ title _____ tuitionfee _____ €

<input type="checkbox"/> Yes, I want to register for the following distance courses without membership.
<input type="checkbox"/> No. 19 title: Ecological Topbar Beekeeping tuitionfee 900 €
<input type="checkbox"/> No. _____ title _____ tuitionfee _____ €
<input type="checkbox"/> No. _____ title _____ tuitionfee _____ €

Payment

- I'll pay in advance by bank payment
- I'll pay directly in advance
- I'll pay by debit. (within Europe incl. Switzerland and England) Here is my bank connection:

IBAN - BIC

Bankinstitute

Surname*, first name*, title: *, Organisation *, hospital *

Time* and place of birth* / Religion*:

Postal address*: , street*, country*, zip-code*, city: *

E-Mail*, Tel.*, Fax:

Questions / notes / place* / date* / signature*