APPLICATION FORM FOR LIFE MEMBERSHIP

IAP INTENSIVE CARE CHAPTER

1. Name _____

2. Sex : Male / Female _____ 3. IAP Membership No. _____

4. Present status & designation _____

_____

5. Permanent Address _____

_____

6. Corresponding Address _____

_____

7. Email _____ _____Mob-_____

8. Telephone No. Office /Chamber_____ Residence_____

9. Date of Birth _____ 10. Nationality _____

11. QUALIFICATION

Medical/Pediatric Qualification	Name of University	Qualifying Year
a. M.B.B.S		
b. D.C.H.		
c. M.D. (Ped)		
d. Others		

_____

Signature

Membership fees : Rs.3000/-

Membership fee must be in Demand Draft in favor of : "**IAP INTENSIVE CARE CHAPTER"** payable at **Satara.**

: For correspondence:

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