

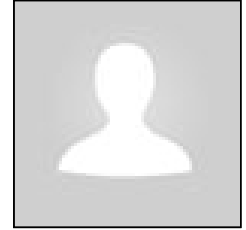
APSI No. :

For Office Use only

Reg. No. :

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ASSOCIATION OF PLASTIC SURGEONS OF INDIA
MEMBERSHIP FORM



A. PERSONAL DETAILS

SURNAME :

FIRST NAME :

MIDDLE NAME :

DATE OF BIRTH : 01-Jan-1970

SEX :

ADDRESS :

CITY :

PIN :

STATE :

COUNTRY :

MOBILE :

E-MAIL :

MEMBERSHIP SOUGHT :

B. PROFESSIONAL QUALIFICATIONS

DEGREE / DIPLOMA	UNIVERSITY	YEAR OF PASSING
M.B.B.S.(Degree Certificate)		
M.B.B.S.(Med. Council Registration Certificate)		
M.S.(Degree Certificate)		
M.S.(Med. Council Registration Certificate)		
M.Ch.(Degree Certificate)		
M.Ch.(Med. Council Registration Certificate)		
D.N.B.(Degree Certificate)		
D.N.B.(Med. Council Registration Certificate)		
F.R.C.S.(Degree Certificate)		
F.R.C.S.(Med. Council Registration Certificate)		

PROPORTION OF PLASTIC SURGICAL WORK / PRACTICE

%

C. DETAILS OF TRAINING & EXPERIENCE IN PLASTIC SURGERY

DESIGNATION	INSTITUTE	FROM	TO	TOTAL PERIOD
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D. AWARDS /PAPERS PRESENTED /PUBLICATIONS /RESEARCH WORK ETC. (IF ANY)

E.MEMBERSHIP OF OTHER ORGANIZATIONS/ PROFESSIONAL ASSOCIATIONS

F. PAYMENT DETAILS

TOTAL AMOUNT PAID :

TRANSACTION REFERENCE NO. :

NAME OF BANK :

DATED ON : 01-Jan-1970

I hereby state that the above facts are true and correct. I undertake to abide by the Constitution and Rules of the Association, if admitted as a member. I am aware that my membership stands cancelled in case of any discrepancy in the information provided and that payment made towards membership fees will not be refunded.

PLACE :

DATE :

SIGNATURE OF APPLICANT

PROPOSED BY : _____

SECONDED BY : _____

SIGNATURE : _____

SIGNATURE : _____

APSI-ID. : _____

APSI-ID. : _____

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Received on ___/___/___ Elected On ___/___/___ E.C. Recommendation: Yes / No. Date : ___/___/___

APSI Membership No. Allocated _____