ASSOCIATION OF PRACTISING PATHOLOGISTS (INDIA)

Registration No: F 18080 (Mumbai)

Office: C-304, Great Eastern Gardens, LBS Marg, Kanjur Marg, Mumbai - 400078

MEMBERSHIP FORM

NAME (IN FULL): Dr. _____

QUALIFICATIONS : _____

MEDICAL COUNCIL: _____ REGISTRATION NO: _____

DATE OF BIRTH: _____ CORRESPONDENCE: CLINIC / RESIDENCE (MARK ONE)

ADDRESS: Clinic _____

_____

Residence _____

_____

TELEPHONE: Clinic _____ Residence _____

Mobile _____ Fax: _____

E-mail: _____ Alternate Email: _____

Special Interest: _____

I, Dr._____ hereby confirm that I agree to abide by the rules and regulations of the Association.

I enclose cash / cheque No_____ for Rs. _____ /- drawn on_____ _____ Bank towards the Life Membership / Professional Associate / Corporate membership.

Date: _____

Place: _____ **Signature**

Please attach the following documents with the form:

1. Colour Passport size photograph (1 no.)
2. Self attested copy of Postgraduate qualification certificate
3. Self attested copy of Medical Council Registration certificate
4. Cheque to be drawn in favour of '**Association of Practicing Pathologists (India)**'

FOR OFFICE USE ONLY:

Membership approved: Yes / No. If No, reason for rejection:_____

Registration No. : _____

Secretary **Treasurer**