



# SURAT PEDIATRIC ASSOCIATION CHARITABLE TRUST

## MEMBERSHIP FORM

AFFIX PHOTO

Name \_\_\_\_\_

[surname]

[first name]

[middle name]

Date of birth \_\_\_\_\_ Sex-Male/Female \_\_\_\_\_

Postal Address \_\_\_\_\_

Telephone s [ office] \_\_\_\_\_

[Resi.] \_\_\_\_\_

Mobile No \_\_\_\_\_

E Mail Id \_\_\_\_\_

Central lap Membership No \_\_\_\_\_

| SR. NO. | MEDICAL QUALIFICATION | NAME OF UNIVERSITY | QUALIFYING YEAR |
|---------|-----------------------|--------------------|-----------------|
| 1       |                       |                    |                 |
| 2       |                       |                    |                 |
| 3       |                       |                    |                 |
|         |                       |                    |                 |

DEGREE REGISTRATION NO \_\_\_\_\_

REGISTRATION AUTHORITY \_\_\_\_\_ YEAR OF STARTING PRACTICE \_\_\_\_\_

NAME OF PROPOSER \_\_\_\_\_

SIGNATURE OF PROPOSER \_\_\_\_\_

DATE \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF APPLICANT

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### FOR OFFICE USE

CHEQUE NO. \_\_\_\_\_

AMOUNT \_\_\_\_\_

RECEIPT NO. \_\_\_\_\_

BANK \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF RECEIVER