



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

FOR OFFICE USE

CHEQUE NO. _____

AMOUNT _____

RECEIPT NO. _____

BANK _____

SIGNATURE OF RECEIVER