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APPLICATION FORM FOR UP AOI LIFE MEMBERSHIP

(FOR OFFICE USE ONLY)		MEMBERSHIP NO	
ELECTED AS			
LIFE MEMBER		SUBSCRIPTION RECIEPT NO	
CORRESPONDING MEMBER			
HONORARY MEMBER		HON. SECRETARY	
		DATE	
[PLEASE TYPE/WRITI	E IN BLOCK CAPITAL]		
1. NAME IN FULL: Dr			
2. DATE OF BIRTH:			
3. ADDRESS:			
4. PIN CODE TELEPHONE NO. (ST MOBILE NO	TD CODE)RES		
DEGREE/DIPLOMA	UNIVERSITY		YEAR OF PASSING
MBBS			
MS			
DLO			
OTHRS			

6. MEDICAL COUNCIL REGISTRATION	N NO., DATE & STATE			
	D TO OTOLARYNGOLOGY			
WITH O	THER BRANCH OF MEDICINE			
8. PRESENT HOSPITAL OR COLLEGE ATTACHMENT				
9. WHETHER MEMBER AOI	IF YES MEMBERSHIP NOOM/LM/CM/AM			
10. I DECLARE THAT THE ABOVE INFORMATION IS TRUE TO BEST OF MY KNOWLEDGE.				
DATE:	SIGN:			
11. LIFE MEMBERSHIP FEE (INCLUDING JOURNAL SUBSCRIPTION) RS. 3000/- ONLY				
12. PAYMENT BY NEFT/DD/CHEQUE/ ONECK SURGEONS (U.P. STATE)	CASH IN FAVOUR OF SOCIETY OF OTOLARYNGOLOGISTS HEAD &			
ACC. NO. -303483				
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13. NOTE:-PLEASE SEND FILLED FORM WITH MEMBERSHIP FEE/FEE DETAILS TO				
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