INDSPN

INDIAN SOCIETY FOR PEDIATRIC NEUROSURGERY

MEMBERSHIP APPLICATION FORM

1. Personal Details

NAME	**FIRST NAME**		
	LAST NAME		
AGE			
GENDER			
NATIONALITY			
QUALIFICATION			
DESIGNATION			
ORGANIZATION			
OFFICE ADDRESS			
		CITY	
		STATE	
		PIN	
RESIDENCE ADDRESS			
		CITY	
		STATE	
		PIN	
PERMANENT ADDRESS (IF DIFFERENT FROM ABOVE)			
		CITY	
		STATE	
		PIN	
TEL NO.			
MOBILE NO			
EMAIL			

2. Membership Type

TYPE OF MEMBERSHIP APPLIED FOR (Circle/Mark Any One)

LIFE MEMBER INR 5000/-	ASSOCIATE MEMBER (LIFE TIME) INR 4000/-	ASSOCIATE MEMBER (ANNUAL) INR 400/-	INTERNATIONAL US $ 200

3. Qualifications

Name of Institution of Medical Degree / University	
Year of obtaining Degree	
Name of Institution of PG Medical Degree / University	
Year of obtaining PG Degree (M.Ch. or Equivalent)	

4. Proposed By (Must Be INDSPN Member)

Name	
Communication Address	
E-mail	
Phone / Mobile No	

5. Seconded By (Must be INDSPN member)

Name	
Communication Address	
E-mail	
Phone / Mobile No	

6. Declaration

I confirm that the above information is correct to the best of my knowledge. I am here by applying for membership of INDSPN. I agree to abide by the rules and laws of the society in force at all times.

Signed: …… Date ……..……...