INDIAN ACADEMY OF PEDIATRICS – U.P. STATE BRANCH

MEMBERSHIP FORM

Personal Information

First Name _____ Middle Name _____Last Name _____

Complete Mailing Address:_____

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Phone Residence: _____ Phone Clinic: _____

Mobile No.: _____Email ID: _____

Are you a member of Central IAP: Yes/No: _____ Central IAP Number: _____

Qualifications:

Qualification	Year of Completion	Institute
MBBS		
DCH		
MD		
DM		
Other (specify)		

Present Attachment: ☐ Teaching(1), PMHS(2), Corporate Hospital(3), Private Practice(4), Other(5)

Remarks (if any)_____

Date: **Signature**

Place:

Attach a DD for Rs. 2000/- in favour of"Indian Academy of Pediatrics UP State Chapter" payable at Agra, U.P.

Please mail the completed form to:

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