



Indian Association of Physical Medicine & Rehabilitation

(Regn. No. S/18608 under the Societies Act)

Regd. Office: Dept. of Rehabilitation, Safdarjang Hospital, New Delhi - 110029

Membership Application Form

Please fill up the form in typed CAPITAL LETTERS in English only.

Affix Photo

1. **Name:** _____

2. **Address:**

A. Permanent Residential Address: _____

Landline: (+) () _____

B. Mailing Address: _____

Landline: (+) () _____ FAX No.: _____

Email address: _____ Mobile : _____

3. **Qualifications:** (Please attach self attested photocopy of your qualification certificates)

S.No.	Examination Passed	Year of Passing	Institution
1.	MBBS		
2.	PG Diploma		
3.	PG Degree		
4.	Any other		

4. Registration details with Medical Council of India / State Medical Council:

No. _____ Date: _____ Council: _____

Registration with Regulatory Authority of Medical Practice in the Country of Work

5. **Appointments & Positions held in the field of Medical Rehabilitation:**

S.No	Post held	Institution	From	To

6. **Special Areas of Interest & Specialization (mention any three in order of priority)**

a. _____

b. _____

c. _____

7. **Date of Birth:** _____

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8. Miscellaneous information (if any) _____

9. Declaration: (*Strike out what is not applicable)

I Dr _____ certify that the statements filled by me in this application form are correct to the best of my knowledge. I agree to abide by the rules and by-laws of the IAPMR which have been read by me. It is hereby requested that my name may kindly be registered as **Life Member (LM)/ Associate Life Member (ALM)/ PGT Member/ Overseas Member/ Honorary Member*** of the IAPMR. I am enclosing the requisite fee for membership as per details below.

My membership is hereby proposed by Dr _____ LM No. _____ of address _____ as endorsed under:.

Signature of the Proposer
(seal)

Signature of the Applicant
(seal)

Dated:-

10. Documentation: (Please attach self attested copies of Qualification, Registration certificates and ID Proof): Yes / No

11. Family Details

Spouse Name		Marriage Anniversary:
Children Names	1. 2. 3.	Dates of Birth

12. Details of Payment:

Payment mode: A/C Payee cheque / Demand Draft / Bank Transfer

Instrument / Reference No.: _____ dated: _____ Amount: _____

Drawn on Bank: _____

Please make payment in favour of 'I A O F P M R' (Savings A/c No. 10874591527, State Bank of India, Ansari Nagar, New Delhi. IFSC Code: SBIN0001536)

Membership Fee: *(Fee subject to change as per prevailing rates at the time of submission of form: updated as of 01/04/2014)*

Life Member: Rs 6500/- (Six Thousand Five Hundred Only) Associate Life Member: Rs 5000/- (Five Thousand Only)

PGT Member: Rs 3000/- (Three Thousand Only) Overseas Member: US\$ 300/- (USD Three Hundred Only)

Please send the completed application form by REGISTERED POST to:

Dr. Chethan C

Treasurer, IAPMR.

Mailing Address:

Room Number 303, Guest House, 3rd Floor, ABVIMS and RML Hospital, New Delhi 110001

Email: treasurer@iapmr.in

For Office Use

Remarks of the Membership Committee: Approved/ not approved / replied / clarification / documentation.

Reciept No. _____ dated: _____ Approved on: _____ (During GBM at _____ with _____ Annual Conference)