MEMBERSHIP FORM

PEDIATRICS ASSOCIATION OF INDIA (PAI)

THE CHILD, B.K. ROAD, RANIHAT CUTTACK-753001, ODISHA

Name of the Applicant:____

Date of Birth: DD/MM/YYYY   Sex: Male / Female

Communication Address: ____

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State:_________________________ Nationality: _______________________

Telephones: (STD Code) ____

Mobile: ____

Email ID: ____

Medical / Pediatric Qualification	Name of the University	Qualifying Year

MBBS Registration No. & Registering Authority (e.g. MCI or State Medical Council):-

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Short Curriculum Viate with area of interest (within 10 lines):-

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Place: Signature of the Applicant

Date:

(In hardcopy)

Recommendation of the Nodal Person:-

The statements above are true to best of my knowledge. His/her membership may be accepted.

Name of the Nodal Person: ____