



Indian Academy of Pediatrics



Chapter of Neuro Developmental Pediatrics

Membership Application Form

(Please fill in capital letters; All Information Mandatory; Pl do not leave any blank spaces)

1. Surname: _____ First Name: _____ Middle Name: _____

2. Date of Birth _____

3. Central IAP Membership Number (For Pediatricians Only) : _____

4. Permanent address:
.....
.....

5. Office Address.....
.....
.....

6. Email:..... Landline Telephone:.....

7. Mobile Phone Number (1).....(2).....

8. Present Work Status: Private __ Govt.__ Medical College__ Voluntary Agency __

9.

Qualifications	Name of University	Year of Passing
MBBS		
MD Pediatrics		
DCH		
DNB Pediatrics		
Others		

10. Areas of Interest of Work _____

P.T.O

11. Membership Subscription:

- a) Life Membership for Central IAP Members – Rs 1000
- b) Life Associate Membership for Doctors other than Pediatricians – Rs 1000
- c) Life Affiliate Membership for All Other Professionals – Rs 1000

12. Demand Draft / Cheque to be drawn in favor of “IAP Chapter of Neuro Developmental Pediatrics” payable at Ernakulam.

On online transfer please e-mail the scanned form with transfer details to cdgiap@gmail.com with cc to leena.sri2012@gmail.com

NAME OF ACCOUNT – **IAP CHAPTER OF NEURO DEVELOPMENTAL PEDIATRICS**
PAYABLE AT ERNAKULAM
FEDERAL BANK LTD
ERNAKULAM / KATHRUKADAVU
ACCOUNT NUMBER **16860100040046**
IFSC CODE – **FDRL0001686**

Signature of the Applicant with date:

For Office Use Only Membership No.....

..... **Particulars of the receipt: Cheque / D.D**

No.....Bank.....

Amount.....Date.....

Mailing address:

Dr Leena Srivastava
Hon' Secretary
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