APPLICATION FORM FOR LIFE MEMBERSHIP
ANDHRA PRADESH CHAPTER OF
ASSOCIATION OF PHYSCIANS OF INDIA

To
The Hony. Secreatery,
Andhra Pradesh Chapter of
Association of Physicians of India,
C/o. Vijaya Nursing Home,
D.No. 21-1-3/1, 2nd Floor,
Jawahar Street, KAKINADA - 533001.

Membership No : _____

Date : _____

(PLEASE FILL THE APPLICATION IN BLOCK LETTERS)

We hereby propose the admission :

Surname

Name

Qualification Year of obtaining Postgraduate Qualification

College

University

Permanent Address

Correspondence Address

City/Town District

Pincode Mobile No.

Phone (Resi) Phone (Off)

E-mail

API Membership No (National Body)

As a ☐ Life Member / ☐ Associate Member of the Association - 3,000/- (Please ✓appropriate)

Demand Draft in favour of Hon. Secretary, " The Association of Physicians Andhra Pradesh Chapter" Payable at "Bank of Baroda" GGH Branch, Kakinada, Account No : 75870100001731, IFSC Code : BARB0VJKGHR

(DD # _____ Dt. _____ Bank : _____

_____
Signature of the Proposer

_____
Singature of the Seconder

Name : _____
Membership No : _____

Name : _____
Membership No : _____

Declaration : All the above information provided is true to the best of my knowledge.
Membership is subject to the approval of the Governing Body in an ordinary or a special meeting. I agree to become a member and if admitted, will abide by the Rules and Regulations of the Association.

Singature of the Candidate

Encl : 1) Above said Demand Draft, 2) One extra photo for ID Card 3) Xerox copy of MD Ceritificate & One Photo Copy of Proof of Identity 4) Post Graduates need to submit MBBS Degree Certificate and bonafide certificate from the Head of the Department.

FOR AP API USE

Scrutiny by Name : Signature

Date :