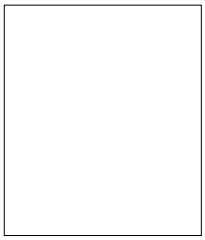
MEMBERSHIP REGISTRATION FORM



Name: _____

Father's /Husband's Name_____

Date of Birth: _____ Blood Group: _____

Qualification: _____

Designation: _____

Registration No: (STATE/CCIM)_____

Residence Address details:

_____

City: _____ State: _____ Pin code: _____

Tel. No:_____ Mobile No:_____

E-mail: _____

Hospital Address details:

_____

City: _____ State: _____ Pin code: _____

Tel. No: _____ Mobile No:_____

E-mail:_____

Web: (if any…) _____

Field of Practice/Clinical Expertise: _____

Qualification Details:

Qualification	**Name of the Year**	**Name of the College**	**Name of the University**
BAMS			
M.D (Ay)/M.S (Ay) Shalya Tantra			
Ph.D			
Any others			

I wish to join the **National Sushruta Association** as a Full Life Member/Associate Life Member and enclose cheque/Draft /NEFT No. _____ dated _____ for Rs. 5,000/- draw on _____ bank/Cash payable at Varanasi towards subscription for the membership. I agree to abide by the rules and regulations of the **National Sushruta Association.** I hereby declare that, I am not involved any activity of misconduct or violation of surgical ethics.

Signature: Date:

Note: Bank drafts are drawn in favour of "National Sushruta Association" payable at Varanasi. Send payment with completed form.