सह वीर्यम करवावहै
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ASSOCIATION OF PHYSICIANS OF AHMEDABAD

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E-mail : ahmedabadphysicians@gmail.com • **Website :** www.apafoum.org.
For More Details Contact : Mr. Mukesh Gohil (PRO, APA) on 09427026374

MEMBERSHIP FORM

Membership Type : Life / Life Associate

Member's Name : _____

Surname First Name Middle Name

Date of Birth : _____

Medical Council. : _____ Medical Council No : _____

Specialty : _____

Residence Address : _____

_____

_____

_____

Hospital Address : _____

_____

_____

_____

Phone No. : (R) _____ (H) _____ (M) _____

Email : _____

Qualification : _____

Blood Group : _____

MarriageDate : _____

Name of Spouse : _____

Spouse Birth Date : _____

Name of Children : (1) _____

Children Birth Date : _____

Name of Children : (2) _____

Children Birth Date : _____

_____
Signature of Member

Receipt No. _____ Date : _____

Amount : _____ Approval Date : _____

APA Membership No. _____

- **Requirement for membership :**
  1. 1 photo copy of registration number of Medical Council.
  2. 1 photo copy of M.D. Certificate.
  3. 1 photo copy of Date of Birth proof.
  4. For Life membership cheque in favour of "Association of Physicians of Ahmedabad".

Passport Size Photograph