Oculoplastics Association of India
Membership Form - Life Member

Name:

Date of Birth (DD/MM/YYYY): Gender:

Highest Educational Qualification:

Medical Council Registration Number:

Fellowship Training Details:

Present Position:

Present Place of Work:

Permanent Address:

Mobile Number:

Email address:

Proposed by: Membership Number:

Seconded By: Membership Number:

I hereby declare that the above details are correct. I wish to be a life member of the Oculoplastics Association of India. I have carefully read the instructions and I shall abide by the rules, regulations and bye-laws of the society as in force and subsequent amendments made.

Signature:

Date: Place: