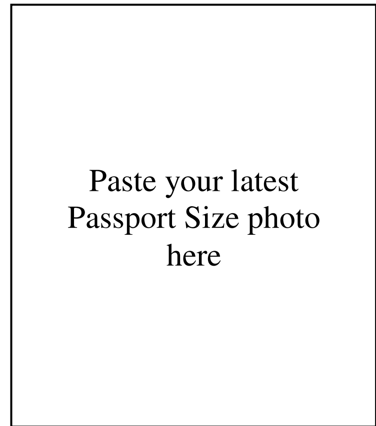
BANGALORE OPHTHALMIC SOCIETY

(MEMBERSHIP FORM)



Name (In Block Letters) ____

S/D/W/o ____

Date of Birth _____________ Qualifications ______________________________

Medical Council ______________________________Registration No. __________

Sub Speciality (if any) ____

Email id: (mandatory) ____
.
Mobile No.:(mandatory)

I. ADDRESS: Clinic/Hospital/Practice : ____

Door No.__________ _______ Cross, _________ Main, Area ____

Stage ______, _________ Phase, Place: BANGALORE Pin_______________Phone ____________________

II. ADDRESS: Residence

Door No.__________ _______ Cross, _________ Main, Area ____

Stage ______, _________ Phase, Place: BANGALORE Pin_______________Phone ____________________

III. ADDRESS: Correspondence

Door No.__________ _______ Cross, _________ Main, Area ______________________________

Stage ______, _________ Phase, Place ____________________________, Pin_______________

Phone ________________

Proposed by

Dr. ________________________________ Membership No. _______ Signature ________________
Seconded by

Dr. ________________________________ Membership No. _______ Signature ________________

(**Please Note :** Life membership fee Rs. 1500/- (Rupees One Thousand Five Hundred only) payable by Demand Draft / Cheques, payable to Bangalore Ophthalmic Society)

Please find enclosed Rs.___________in words ____

By Cash/Cheque/DD No.____________________ Dated____________ Drawn on_____________________

I agree to become a life member of the Bangalore Ophthalmic Society and shall abide by the Rules and Regulations of the Society.

Signature of Applicant