

# INDIAN ASSOCIATION OF GYNAECOLOGICAL ENDOSCOPISTS

## APPLICATION FOR LIFE MEMBERSHIP

I hereby apply to be elected as Life Member of INDIAN ASSOCIATION OF GYANECOLOGICAL ENDOSCOPISTS (IAGE). I am herewith sending the entrance and membership fees by

Demand Draft No: \_\_\_\_\_ Dated \_\_\_\_\_

For **Rs. 5000/-** on \_\_\_\_\_ (bank)

in favour of '**IAGE**' payable at **Mumbai**.

Life Membership fee : Rs. 5,000/- Till 31<sup>st</sup> Dec.2011. (Rs.7500/- from 2012 onwards.)  
(additional Rs. 100/- for cheques from out of Mumbai as Bank clearance)

Eligibility : Life Member must be MBBS with post graduate qualification in Obstetrics and Gynaecology. (Please attach attested Xerox copies of the qualification certificate)

1. Name in full : \_\_\_\_\_

2. Address in full: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ Pin Code: \_\_\_\_\_ State: \_\_\_\_\_

Tel: No: \_\_\_\_\_ Mobile No: \_\_\_\_\_

Email: \_\_\_\_\_

3. Degrees and diplomas with dates:  
\_\_\_\_\_

4. State Medical Council Registration No: \_\_\_\_\_

5. Date of Application : \_\_\_\_\_

Recommended by:

1. \_\_\_\_\_ Signature: \_\_\_\_\_

2. \_\_\_\_\_ Signature: \_\_\_\_\_

(Recommendation of two IAGE members is necessary. In case the applicant is unable to obtain the same, the secretary will do the needful in the Association office.)

For Office Use:

Date of receipt form: \_\_\_\_\_

Enrolled on \_\_\_\_\_ as a Life Member

Dr. Rajesh Modi  
Hon. Gen. Secretary

Dr. P. K. Shah  
President

Secretariat -

c/o Dr. P. K. Shah, IAGE President  
121, Vitthalwadi, 3rd floor Kalbadevi Road  
Mumbai 400002 Maharashtra. India

Contact : Tel: (022) 22431423  
Website: [www.iageonline.com](http://www.iageonline.com)  
email: iageonline@hotmail.com

For details contact:

Dr. Rajesh Modi  
Akola Endoscopy Centre  
Alsi Plots, AKOLA 444001  
email : [rajeshmodi99@hotmail.com](mailto:rajeshmodi99@hotmail.com)  
Tel : 9823120020, 07588758001.

# IAGE MEMBER DETAILS

NAME: \_\_\_\_\_

SEX: (M/F)

DATE OF BIRTH: \_\_\_\_\_

QUALIFICATION: \_\_\_\_\_

NAME OF SPOUSE: \_\_\_\_\_

ANNIVERSARY: \_\_\_\_\_

ADDRESS:

CLINIC: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

RESIDENCE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ATTACHMENTS: \_\_\_\_\_

TELEPHONE No's:

CLINIC: \_\_\_\_\_ RESIDENCE: \_\_\_\_\_

MOBILE: \_\_\_\_\_ FAX: \_\_\_\_\_

Email: \_\_\_\_\_ WEBSITE: \_\_\_\_\_

