FOUNDATION FOR HEAD AND NECK ONCOLOGY

(Registered under Charitable Societies Act)

MEMBERSHIP FORM

Name : _____

Age / Date of Birth : _____

Professional Qualification :
(With year and Institution) _____

Address for communication : _____

_____

_____

Tel. No. Office _____

Residence _____

Mobile _____

E-mail ID : _____

Present position : _____

Area of interest / expertise : _____

Signature

Type of membership : (Please Select)

☐ Life member (Rs.7500/-) Open to all medical professionals holding a recognized post graduate degree in the concerned specialty

☐ Life Associate Member (Rs.7500/-)Open to all paramedical professionals involved in the specialty

Details Cheque no / NEFT _____

Date _____

Amount _____

Bank _____