Oculoplastics Association of India

Membership Form ⁻ Life Member

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