## **MEMBERSHIP APPLICATION FORM (2024-25)**

(TO BE FILLED IN 'ALL CAPITALS' PLEASE)

| Last Name:                               | First Na                       | me:                                    | Middle Name:                                    |
|--|--------------------------------|--|---|
| Date of Birth:                           | Sex: Resi. A                   | address: (Detailed with PIN CODE)      |   |
|  |                                |  |   |
| Clinic Address: (Detailed with PIN CODE  | please)                        |  |   |
|  |                                |  |   |
| Please add Country and Area Code befo    | re telephone numbers: (Eg      | +91 22)                                |   |
| Residence Phone:                         |                                | Residence Fax:                         |   |
| Clinic Phone:                            | Clinic Fax:                    | Mobi                                   | le:   |
| E-mail:                                  |                                | Website:                               |   |
| Qualifications*: (Degree / Diploma; Univ | versity & Year of Passing)     |  |   |
|  |                                |  |   |
| Registration*: (Number, Name of Medic    | al Council & Year of Registra  | tion)                                  |   |
|  |                                |  |   |
|  |                                |  |   |
| ·  |                                |  |   |
|  |                                |  |   |
| Recommended by: (Names, Signatures       |                                |  |   |
| 1  |                                | 2                                      |   |
| I am enclosing a Demand Draft or payal   | ble at par Cheque No           | of Rs. 7                               | 7500/- (Indian Rupees Seven Thousand Five       |
| Hundred Only) in favour of 'Bombay O     | rthopaedic Society', payable   | e at Mumbai, of                        | Bank,   |
| dated                                    | for my Life / Asso             | ociate Membership of the BOS. My       | membership will be confirmed on realization of  |
| D.D. / Cheque, receipt of completed for  | m with proof* of qualification | n and registration. It will be subject | to ratification by the General Body of the BOS. |
| Signature of Applicant:                  |                                |  | Date:   |

## **IMPORTANT NOTICE:**

- Please attach photocopies of MS (Orth) / D. Orth / D.N.B. pass certificate & Medical Council Registration certificates along with this form.
- Signature of 2 Life Members along with their membership number is mandatory. Otherwise you will not be considered for membership.
- Please attach copy of your permanent postal address proof (for eg. - Aadhar Card, Passport, Driving Licence)



**BOMBAY ORTHOPAEDIC SOCIETY** 

Please send duly filled form along with DD to Dr. Ashish Phadnis, Hon. Secretary,

**BOMBAY ORTHOPAEDIC SOCIETY** 

VAMA EVENTS PVT. LTD. Kohinoor Square Phase I, B Wing, Office No.1004, 10th Floor, N. C. Kelkar Road, Shivaji Park, Dadar West, Mumbai - 400 028

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