Indian Association of Medical Microbiologists
Delhi Chapter
www.iammdelhi.com

Membership No. LM/PGM_____
Validity of Membership: _____
(official purpose only)

Membership Form

Name: (First)_____ (Middle)_____ (Last)_____

Name as you would like to appear in records: _____

Date of birth_____ Age (Completed Years) _____ Sex_____

Qualifications: _____ No. of years in the specialty _____

Year of passing M.B.B.S. _____ University/College _____

Year of joining MD_____ Likely date of completion of MD: _____

Year of joining PhD: _____ Likely date of completion of PhD:_____

Specialization_____

University/College _____Any Other (Please Specify)_____

Residential Address (Present): _____

_____

City: _____ Pincode: _____ State:_____

Tel. (Res.):_____ Mobile:_____ Fax_____

E. Mail:_____

Residential Address (Permanant): _____

_____

City: _____ Pincode:_____ State:_____

Official Designation/ Affiliation: _____

Official Address: _____

_____

City: _____ Pincode:_____ State:_____

Tel. (Res.):_____ Mobile:_____ Fax_____

E. Mail:_____

Awards/Fellowships*:

_____

_____

_____

Area of Research interests*_____

Would you like to be involved with promotion of the cause of Medical Microbiology *: Yes/No (If Yes, please specify mode: Scientific / Academic / Research / Financial /Others)

_____

_____

_____

**optional*

Minimum one time contribution:
Microbiologists: Rs. 1,500/-
Post graduate students (Medical Microbiology): Rs. 500/-**
** (subject to a further contribution of Rs.1000/- after post graduation)

NOTE:
Please attach a crossed Cheque / D.D favoring **'Indian Association of Medical Microbiologists-Delhi Chapter'** payable at Delhi. *Cash is NOT preferred.*

Paid via Cash or Cheque/DD No. _____ Dated _____

Drawn on (Bank Name and Address): _____

Signature:

Place: _____Date :_____

Register online at www.iammdelhi.com to activate your membership.