**Associate Membership Application Form**

**First Name**\_\_\_\_\_\_\_\_\_\_ **Middle Name**\_\_\_\_\_\_\_\_ **Last Name** \_\_\_\_\_\_\_\_\_\_

**Age**\_\_\_\_\_\_\_\_\_\_\_ **Sex** \_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_

**Address (Res.)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address (Clinic)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pin:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pin:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tel:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Tel:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Institution/ Hospital Affiliations (Teaching / Non-Teaching)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Qualification and year of acquiring of it** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Preferred Address for Correspondence: Home / Office / Clinic (please specify one)

Life Membership (India) fee of Rs. 5000/- to be paid by NEFT

Associate Life Membership fee of Rs. 1000/- to be paid by NEFT

**NEFT Transaction Details**

HDFC Bank

**Account Name**: Indian Society of Medical and Paediatric Oncology

**Account No: 50200001602442**

Address: 386, Veer Savarkar Marg, Opp. Siddhivinayak Temple, Prabhadevi, Mumbai – 400025  
RTGS / NEFT IFSC : HDFC0000012

Date of transfer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NEFT Transaction ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attachment Required: DM/DNB Oncology Certificate / Others (Please Specify):

Email the membership form, transaction details along with degree certificate  
on [**ismposecretary@gmail.com**](mailto:ismpo.secretary@gmail.com)

1. I am aware that only medical oncologists are eligible for full membership.
2. Associate life members consist of qualitied medical persons as well as scientists not actually practicing medical & paediatric oncology.
3. Younger Physicians intending to specialize in oncology also may become associate life members.
4. I understand that submission of the membership application form and the membership  
   dues does not automatically make me eligible to be a member. Decision of the  
   executive committee and general body of ISMPO will be final binding.
5. I agree to comply with and uphold ISMPO constitution and byelaws.
6. Continuation of membership will require my ongoing commitment and active contribution to the activities of ISMPO.
7. I hereby confirm that the attached certificate provided along with this application  
   is genuine.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proposed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seconded by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_