INDIAN ACADEMY OF PEDIATRICS
Infant Young Child Feeding Chapter
MEMBERSHIP FORM

Name of the applicant:----------

(Surname) (First name) (Middle name)

Date of Birth:---------- Sex: ----------

Central IAP Membership no. ----------

Address for Correspondence:

Telephone No:- Resi. ---------- Hosp. ----------

Mobile other:-

Fax:---------- E-mail ----------

Pediatrics/Nutrition qualification	University	Year

Experience in field of child nutrition (if any) ----------

Name, membership no. & signature of proposor :----------

Name, membership no & signature of secondor :----------

Place: ----------

Date: (signature of applicant)

Life Membership fee: **Rs. 1000/- (one thousand only) by DD**, in the name of **IYCF chapter of IAP payable at Amravati Maharashtra**. Please send the DD to dr. Ketan Bharadava, Surat, Dr Sanjio Borade Amravati, **or to** Dr RK Agarwal (c/o R K Hospital 5/A Madhuban Udaipur 313001 Rajasthan

(This form can be photocopied)