MEMBERSHIP FORM OF AORA
(ACADEMY OF REGIONAL ANAESTHESIA OF INDIA)

Name : ....

Age: .... Date of Birth : …............................ Sex : ....

Qualification with Institution : ....

Internship : ....

D.A. : ....

MD (Anaesthesia) : ....

Mailing Address : ....

....

Permanent Address : ....

....

Contact Numbers: Home ....

Office : ....

Mobile : ....

E Mail Address : ....

Current Position : ....

Number of Years in Practice : ....

Medical Council Registration Number : ....

Fees can be paid either in Cash, Cheque or DD drawn in favor of
“Academy of Regional Anaesthesia”

Amount : Rs. 3,000/-

DD / Cheque No.: ……... Dated : ....

Bank Name & Branch : …...

Signature of the Applicant Date : ....

SECRETARIAT
DR. VRUSHALI PONDE
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