



MEMBERSHIP APPLICATION FORM

Please Tick () the appropriate Boxes

Name :

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First Name

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Middle Name

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Last Name

Speciality:

☐ Life Member

☐ Associate Member

☐ Endodontics
☐ Periodontics
☐ Prosthodontics

Name of the Institution or Hospital Attached to:

A) PERMANENT ADDRESS :

Pin: _____ Phone: _____

B) PRESENT ADDRESS :

Pin: _____ Phone: _____

C) CLINIC / COLLEGE ADDRESS :

Pin: _____ Phone: _____

Mobile: _____ Blood Group: _____ Date of Birth: _____

Email: _____

Preferred communication address : A) ☐ B) ☐ C) ☐ D) Email: ☐

I declare that I have read the byelaw and constitution of **Indian society of Prosthodontics-Restorative Periodontics** and agree to abide by it.

I am herewith sending a Demand Draft of Rupees 5,310/- as my **Life / Associate Membership** fee by

DD No.: _____ Dated: _____ Bank: _____

DATE: _____

Send Application form with D/D drawn in favour of ISPRP payable at Mangalore, Karnataka and supporting documents by counter or registered post to **Dr Manuel S Thomas, Dept. of Conservative dentistry and Endodontics, MCODS, Mangalore, Karnataka 575001, India. Mobile/ WhatsApp: +91-9980981150**

FOR OFFICE USE ONLY

1. Date of receipt of application:
2. D/D No. and Bank :
3. Date of Executive Meeting
in which it was accepted :
4. Membership No. :
5. Signature of Secretary :

Bank Account Details

Account No.	:	02452200041220
Bank Name	:	Canara Bank
Branch	:	ABSMIDS Branch
IFSC Code	:	CNRBINBBBFD