# POONA OPHTHALMOLOGICAL SOCIETY

## Membership Form

**Title:**

**First Name:** *

**Last Name:** *

**Sex:**

- ☐ Male
- ☐ Female

**Email Id:** *

**Designation Year:**

Please enter current year Ex : 2018

**Designation:**

**Achievement:**

**Degrees:**

**Allopathy/others:**

- ☐ Allopathy

**Clinic Landline no:**

**Residential Landline no:**

**Mobile No:** *

**MMC Registration no:**

**Clinic Address:**

**Residence Address:**

**Preferred Postal Address:**

- ☐ Clinic
- ☐ Residential

**Date of birth:**

**Marriage Anniversary:**

**ICard size photo:**