POONA OPHTHALMOLOGICAL SOCIETY

Membership Form

Title :

First Name : *

Last Name : *

Sex :
- ☐ Male
- ☐ Female

Email id : *

Designation Year :

Please enter current year Ex. : 2022

Designation :

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 Brith :

Marriage Anniversary :

I Card size Photo :

Proposed by :

Seconded by :

Please send the completed form by post/courier or deposit Physically to the POS Secretariat, along with a print of MBBS, Postgraduation Certificate and MMC/MCI Registration Certificate