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) can be paid by online transfer** in the bank account of **IYCF chapter of IAP**. Please send filled form to Dr. Satish Tiwari, Yashoda Nagar no. 2 Amravati 444606 Maharashtra OR You can email the form and payment details on mail id drsatishtiwari@gmail.com.

(This form can be photocopied)