

***Greater Charlotte Association of American Physicians of Indian origin.***

***Membership form.***

1. **Annual membership: $ 75. ( valid from Nov 1,2014 to Oct 31 2015)**

1. **Life membership: $ 750.**

***Details:***

**Name**:…………………………………………………………………………………………………….

**Specialty**:………………………………………………………………………………………………..

**Medical School**:………………………………………………………………………………………………………………………..

**Family** :………………………………………………………………………………………………………………………………………….

**Address**: …………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………

**Email**:………………………………………………………………………………………………………………

**Tel**:.......................................................................................................................

**Practice Location**:………………………………………………………………………………………………………………………………

**Payment method: …………………………………………………………………………………….**

**Payment date:…………………………………………………………………………………………..**

**Signature:**……………………………………………………………………………………………………