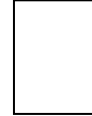


**APPLCATION FORM FOR MEMBERSHIP OF THE ASSOCIATION  
UROLOGY SOCIETY OF INDIA WEST ZONE**

**1. Name** \_\_\_\_\_  
(in Block letters)                      First                      Father's                      Surname



Enter in this box the  
alphabet under which  
you would like your  
name to be listed

**2. Birthdate** \_\_\_\_\_

**3. Address ( Permanent Mailing Address)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pin \_\_\_\_\_  
Tel : (office) \_\_\_\_\_  
Tel : (Resi) \_\_\_\_\_  
Tel : (Fax) \_\_\_\_\_  
Email \_\_\_\_\_

**4. Present Appointment and Designation**

Designation of Joining	Institution	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

**5. Academic Qualifications**

	University / Body	Year of passing
M.B.B.S.	_____	_____
M. S.	_____	_____
M. Ch.	_____	_____
D.N.B.	_____	_____
Other	_____	_____

6. Medical Council Registration No and Date: \_\_\_\_\_

7. Training In Urology

Institution	Duration From	To
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. USI Member : Yes/No If Yes, USI Membership No. \_\_\_\_\_ Full/Associate

9. Category of USWZ membership applied for : Full/Associate

10. Membership Fee (Life) Rs 3000, Admission Fee Rs 100. **TOTAL Rs 3100**

Details of Payment : Cash/Draft/Cheque No \_\_\_\_\_ Dated \_\_\_\_\_ Drawn  
on \_\_\_\_\_ (please add Rs 25 for outstation cheque) for Rs \_\_\_\_\_

I declare that the information given above is correct and if elected, I agree to abide by the Constitution of Association of Urologists of West Zone of India.

Date : \_\_\_\_\_

Signature :

Place : \_\_\_\_\_

Name :

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Proposed by :

Seconded by :

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Designation \_\_\_\_\_

Designation \_\_\_\_\_

USI No. \_\_\_\_\_ USWZ No. \_\_\_\_\_

USI No. \_\_\_\_\_ USWZ No. \_\_\_\_\_

(Sponsors should be Full Members of Urologist Society of India West Zone)

\*\* Please attach certified copies of documents for qualifications and training in Urology