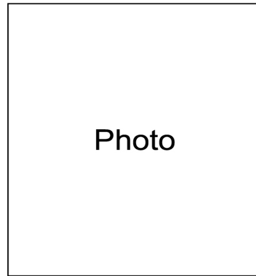
Airway Management Foundation
Membership Form



Name: ______________________________

Profession: ☐ Doctor ☐ Nurse ☐ Paramedic ☐ Others ______________________________

Specialty: ☐ Anesthesiologist ☐ Intensivist ☐ Pulmonologist ☐ Life Support Instructor

Otorhinolaryngologist ☐ Others ______________________________

☐ Institution ☐ Hospital ☐ Place of work: ______________________________

Designation: ______________________________

Address for Correspondence: ______________________________

Contact Number(s): ______________________________

Email: ______________________________

Amount (INR): ☐ 1000 ☐ 5000

Payment Type: ☐ Cheque ☐ Demand Draft ☐ RTGS ______________________________

Drawn on (Bank Name): ______________________________

Dated: ______________________________

Date: ______________________________ Signature:

Membership Process

Membership	Charges
Individual Life Member	Rs. 5,000/-

* Please make cheque/DD/Payorder in favor of "Airway Management Foundation" payable at Delhi.

Office:

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