Academy of Health Professionals (AOHP)

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E-mail: ahppaonta@gmail.com; contact@aohp.in
Website: https://aohp.in/

Photo

Membership Form

Dear Sir /Madam

I wish to enroll as Annual/Life Member of " **Academy of Health Professionals**" I agree to abide by the Memorandum, Rules and Regulations of the Society as framed from time to time.

Name and Last Name _____
(Prof./Dr./ Er./Mr./Mrs./Ms.)
Male/Female _____
Date of Birth _____
Organization Address _____
_____
_____
Correspondence Address _____
_____
_____
City, Pin Code, State _____
Country _____
Mobile _____
E-Mail _____
Educational Qualifications _____
Area of Specialization/ _____
Current research Interest

Sincerely yours

Place _____ Date: _____ Signature_____

NATURE OF MEMBERSHIP

	Indian	Foreign
Annual subscription:	Rs. 500/-	**US $50**
Life subscription:	Rs. 2000/-	**US$ 100**

Note: Fill the form, and send it through attachment file at **ahppaonta@gmail.com; contact@aohp.in**

Details of Beneficiary
Academy of Health Professionals
Account number: 921020047762709
IFSC Code: UTIB0002901
Axis Bank, Ground floor, Upsampada,
Paonta Sahib, Sirmour, H.P., India.