



INDIAN ASSOCIATION FOR GERIATRIC MENTAL HEALTH

Committed to quality mental health care for the elderly

Reg. No. 268/2004-5

Website <https://iagmh.org/>

MEMBERSHIP FORM

1. Name:

Preferred Salutation (e.g., Dr., Prof. etc.):

Family Name:.....

First Name:

Middle Name :

Credentials/Degrees: (e.g.. MD., FRCP, FRCPsych, Ph.D, M.Phil, etc.):

Please write your name exactly as you would like it to appear on correspondence, with preferred salutation (e.g., Prof., Dr., Mrs., Mr., M/s etc.).....

2. Qualifications:

3. Year of Passing MD/DPM/DNB:

4. Date of Birth (MM:DD:YY) : **5. Gender:** Male Female

6. Business Mailing Address and Telephone:

Business E-mail Address :

Name of Business:.....

Street Address :

City, State, Postal Code : Country:

Country code/City code/Local number..... Telephone:

Mobile :

7. Home Mailing Address and Telephone:

Home E-mail Address :

Street Address :

City, State, Postal Code : Country:

Country code/City code/Local number..... Telephone:

Mobile :

8. Please indicate if you prefer to receive E-mail from IAGMH your home or business E-mail Address

(a) Home E-mail: (b) Business E-mail:

9. Please indicate your professional discipline (s): (You may choose more than one):

- | | | |
|--|---|--|
| <input type="checkbox"/> Geriatric Mental Health | <input type="checkbox"/> General Adult Psychiatry | |
| <input type="checkbox"/> Child & Adolescent Psychiatry | <input type="checkbox"/> De-addiction | <input type="checkbox"/> Geriatric Medicine |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Neuro-Surgery | <input type="checkbox"/> Neuro-Psychopharmacology |
| <input type="checkbox"/> Neuro-Anatomy | <input type="checkbox"/> Neuro-imaging | <input type="checkbox"/> Other Neurological Sciences |
| <input type="checkbox"/> Public Health | <input type="checkbox"/> Life Sciences | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Others, please specify: | | |

