Pakistan Academy of Pediatric Dentistry

MEMBERSHIP FORM

For Office Use Only	
PAPD. No	
Date	

Doctor's Name: _____

Father/Husband Name: _____

Designation:_____ PMDC No:_____

Institutional Address_____

Home/Clinic Address_____

Email ID: _____Cell Phone: _____

I solemnly affirm that I will abide by all the rules and regulations of Pakistan Academy of Pediatric Dentistry (PAPD) in the best interest of my pediatric patients and PAPD, Pakistan.

Membership Type _____ For the Calendar Year: _____
Amount: _____ Bank DD/Online Transfer/IBFT Receipt Copy Attached: Yes/No

Member's Signature: _____

*Finance Secretary's Signatures*_____*President's Signature:*_____

**Please complete this Form and send by post to 222 Defence Raya Golf Club, Phase 6, DHA, Lahore Cantt. Or send as email attachment to drsajjadahmad1@gmail.com. You will then will guided how to despite your membership fee.*