

Society of Endoscopic and Laparoscopic Surgeons of India (SELSI)



Room No. 5031/5023, 5th Floor, Teaching Block, Department of Surgical Disciplines
 All India Institute of Medical Sciences, New Delhi - 110029, India
 Website : www.selsi.in E-mail : secretary.selsi@gmail.com
 Phone No +91-11-26594769,+91-11-26594776, Fax No. +91-11-26588324

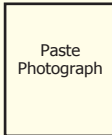
MEMBERSHIP FORM

To
 Hon. Secretary
 SELSI

Sir,
 I wish to apply for the membership of SELSI under the following category and I affirm that I will abide by rules and regulations of SELSI, if my membership is approved by the Executive Committee of SELSI.

Membership Type Please Tick

- Life Member
 Associate Member
 Overseas Member
 Corporate Member



Applicant's Information

Name _____ Surname _____
 Date of Birth _____ Nationality _____

Professional Address

Institution _____
 Department _____
 Address _____

Address for correspondence

City _____
 State _____
 Pin Code _____
 Phone _____
 Fax _____
 Email _____

Education

	College / University	Year of Passing
MBBS		
Post Graduation		
Super Specialty		

Are you a

General Surgeon Gynaecologist Urologist Surgical Oncologist
 Paediatric surgeon Endoscopist Others, please specify _____

For Official use only :

Membership approved : Yes No
 SELSI No. _____
 Confirmation sent on : _____

www.selsi.in

Medical Council Registration

Registration No _____ State _____
 Whether an active members of ASI ? Yes / No
 Registration No _____ State _____

Whether a Member of any other National and International Organization :

SAGES EAES AMASI IAGES OTHER (Please mention _____)

Current Endoscopic / Laparoscopic Experience:

Procedure	Number in last 12 months	Number in last 2 yrs.

Was laparoscopic surgery a part of your postgraduate training, if yes, name of institution _____

Have you had formal training in laparoscopic/endoscopic surgery, if yes, where _____

Sponsors

Two members of SELSI /or Two Senior Surgeons of your Area / or Two of Your Colleagues

Signature of Sponsor 1 _____

Name _____

M. No. _____

Signature of Sponsor 2 _____

Name _____

M.No. _____

Payment Details

Draft/ Cheque No. _____ Dated _____

Drawn on _____

Amount Rs. _____

Date _____

Place _____

Signature of Applicant _____

Membership Fees

Life Members Rs. 1,000/-
 Assoc. Members Rs. 1,000/- (PG Students only)
 Overseas Members 50 USD
 Corporate Members Rs. 5,000/

To be enclosed:

1. Copy of post graduate degree certificate
2. Two passport size photographs
3. Demand Draft, in favor of "SELSI" payable at SBI, Ansari Nagar, New Delhi, India

The complete application form may be mailed to:

Secretary SELSI

Room No. 5031/5023, 5th Floor, Teaching Block,
 Department of Surgical Disciplines
 All India Institute of Medical Sciences,
 Ansari Nagar, New Delhi - 110029, India

Dr. Amit Srivastava

1/114-B, Babu Gulab Rai Marg,
 Delhi Gate,
 Agra - 282002 UP
 +91- 9897022008

www.selsi.in