ASIA PACIFIC ARTHROPLASTY SOCIETY

MEMBERSHIP FORM

Title: Profe ssor/Doctor/Mr/Mrs

Surname: _____

First name:_____

Sex: ____ Date of birth_____

Nationality: _____

Postal Address for Correspondence:

_____

_____

Tel. No. (Private) (Country code/City code) _____

Tel. No. (Office)(Country code/City code)_____

Fax: _____

Email: _____

Professional Details:
Degree: _____

Position: _____

Institution: _____

TYPE OF MEMBERSHIP	**FEES**
1. Ordinary Member	US$ 95 (For 3 years)

Payment :

Card: VISA…..Mastercard…..Number……

Name on card……..….Exp…./….

Signature:……