American Association of Physicians of Indian Origin Queens and Long Island

MEMBERSHIP APPLICATION FORM

Name: Sex: M / F

Name of Medical School:

State: Year of Graduation:

Specialty: Sub Specialty:

Home Address:

Office Address:

Email: Cell: Home:

NY State Medical License:

Active/Inactive Member of National AAPI Yes/No

Life Membership Fee $200.00 (Individual) $350.00 (Spouse if both MD)

Name of Spouse: Sex: M / F

Name of Medical School:

State: Year of Graduation:

Specialty: Sub Specialty:

Home Address:

Office Address:

Email: Cell: Home:

NY State Medical License:

Active/Inactive Member of National AAPI Yes/No

Name of Children: M / F MD Yes/No

Name of Children: M / F MD Yes/No

Name of Children: M / F MD Yes/No

I certify all above information is correct and subject to verification before granting me membership as per AAPIQLI bylaws (LINK TO Bylaws)

Signature: Date:

Signature Spouse: Date:

Nomination by AAPIQLI Member

Name: Signature:

Approved by: Yes/No

Membership Committee Chair / President / Chair BOT

Please mail the form to: 3 Parkway Drive, Roslyn Heights NY 11577 or email: ichhabra@leffertsmedical.com