INDIAN PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

MEMBERSHIP FORM

First Name	Middle Name (Optional)	Last Name
Address		
Qualification and Work Experience		

Area of interest (Please select ✓all that apply.)

General Paediatrics	General Surgery	Hospital Administration
Developmental Paediatrics	Reconstructive and Plastic Surgery	Public Health
Adolescent Health	Gender Affirmation Surgery	Preventive Healthcare
Paediatric Endocrinology	Urology	Care of the Elderly and aging LGBTQI person
Paediatric & Adolescent Psychiatry	Facial Surgery	Medical Education and Health Policy
Primary Healthcare & Family Medicine	Vocal Cord Surgery	Education
Internal Medicine	Speech Vocal and Voice therapy	History and Cultural Anthropology
Endocrinology	Dermatology & Cosmetology	Social Work / Political Science / Sociology
Reproductive and Sexual Healthcare	Hair Therapy / Electrolysis & Laser Therapy	Theological studies and research
Sexology/Sex Therapy	Hair Transplant	Gender studies and Gender Education
Sexually Transmitted Diseases, HIV, AIDS	Emergency Medicine	Marriage Counselling and Family Therapy
Gynaecology & Cosmetic Gynaecology	Physical Therapy	Behavioural Therapy
Psychiatry	Research in Mental & Physical Health issues of LGBTQI	Pharmacology
Clinical Psychology	Suicide Prevention	Creating Gender Friendly Safe Spaces
Medico-legal Issues	Ethics	Laws, Legislation and Human Rights

INDIAN PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

Company Information

Comp **any/Institution**
Department and Designation
Mobile Phone
Website
Email Address

I am opting for (please tick ✓ one of the following):

Lifetime membership (INR 7,500/-)	☐
Annual membership (INR 2,000/-)	☐
Annual Student membership (INR 1,000/-)	☐

Declaration: I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it. I hereby authorize sharing of the information furnished on this form with the Association for Transgender Health in India (ATHI), New Delhi and it's subsidiary arms Indian Professional Association for Transgender Health (IPATH) and KHEM.

Place _____ Date _____ Signature _____

PAYMENT DETAILS

All payments to be made in favour of :-

"ASSOCIATION FOR TRANSGENDER HEALTH IN INDIA"
PAN Number : AARCA5356K
TAN Number : DELA51889F
GSTIN Number : 07AARCA5356K1Z5

Account Number : 10032154029
IFSC Code : IDFB0021001
IDFC BANK
GOLF COURSE ROAD BRANCH
ONE HORIZON CENTER,
GOLF COURSE ROAD
GURGAON , HARYANA – 122003

Payments can also be made through UPI

VPA : 8860944900@upi

Postal Address for mailing of the Cheques and completed IPATH Membership Forms is :-

Dr RICHIE GUPTA MS MCH (Plastic Surgery)
DIRECTOR
INDIAN PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH
A-1 / 11, JIVAN JYOTI APPARTMENTS
KABIR DASS MARG, PITAMPURA
NEW DELHI – 110034

Please note that your membership will be considered complete only upon submission of the following:

1. Confirmation of payment made in favour of Association for Transgender Health in India (ATHI)
2. Detailed individual profile listing professional qualifications and supporting documents
3. Identity Proof and PAN Card
4. Two recent passport size photographs