



Indian Pharmaceutical Association

Kalina, Santacruz (E), Mumbai - 400 098.
Tel : 91-22-2667 1072 Fax : 91-22-2667 0744
E-mails: ipacentre@ipapharma.org
www.ipapharma.org

Membership Form

Fields with a * are required to be Filled (in BLOCK LETTERS) otherwise IPA would be unable to process this form.	FOR OFFICE USE ONLY	
	Membership No.	Date of Admission No.
Hon. Gen. Secretary		

Personal Information

Designation* : Dr. Mr. Ms.
Name* : _____
Last Name First Name Middle Name
Date of Birth* : _____
DD / MM / YY

Mailing Address

Address* : _____
Street* : _____
Town / City* : _____
State* : _____
Country* : _____
Pin code* : _____
Tel no. * : _____
Mobile no. : _____
Fax : _____
E-Mail* : _____

Home Address

Address* : _____
Street* : _____
Town / City* : _____
State* : _____
Country* : _____
Pin code* : _____
Tel no. : _____



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Professional Address

Job Title* : _____
Name of organization* : _____
Address* : _____
Street* : _____
Town / City* : _____
Country* : _____
State * : _____
Pin code* : _____
Tel. No. * : _____
E-Mail : _____

Branch Information

Local Branch* : _____
State Branch* : _____

Qualification* : D. Pharm
 B. Pharm
 M. Pharm
 Ph.D.
 B.Sc.
 M.Sc.
 Others (specify) _____

Membership Information

I wish to apply as* : Patron Rs. 50,000
 Life Member Rs. 6,100
 Life Member (Senior citizen) Rs. 3,100
 Ordinary Member Rs. 700
 Institutional Member (General) Rs. 12,000
 Institutional Member
(Hospital / Community Pharmacy) Rs. 6,000
 Associate Life Member Rs. 7,000
 Associate Ordinary Member Rs. 1,100
Student Member



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- Degree course : 1st year Rs. 750
 2nd year Rs. 450
 3rd year Rs. 300
 4th year Rs. 150
Diploma course : (2 years) Rs. 300
 Student Life Member (for degree students only)
Rs. 1500 per year
 Foreign Member (Others) US \$ 25
 Foreign Member (US, EU, Japan, Australia) US \$ 100

Present Information

- Present Classification* : Manufacturing Pharmacist
 R & D Chemist / Scientist
 QA / QC Analyst
 Marketing
 Teacher
 Regulatory
 Hospital / Community Pharmacist
 Retail / Wholesale Pharmacist
 Manufacturer
 Other (specify) _____

- Divisional Preference* : Industrial
 Education
 Regulatory
 Community
 Hospital

Reference of two members of IPA *

- 1) Member Name : _____
Last Name First Name Middle Name
IPA membership no. : _____
- 2) Member Name : _____
Last Name First Name Middle Name
IPA membership no. : _____



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Endorsement from institute (for student members only)

Certified that Mr. / Ms. _____ is a
bonafide student of _____ and is studying
in _____ degree / diploma course.

SEAL OF THE INSTITUTE

Signature of the Principal

I agree to abide by the Rules & Regulation of the Association.

Signature of Applicant

Subscription Information

I wish to subscribe to IJPS : 1 year Rs. 750
 3 years Rs. 1,200
 5 years Rs. 2,000
 Do not subscribe

Amount Information

Membership Fees : _____
IJPS Subscription : _____
Outstation Bank charges : _____
Total : _____



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Payment Method

Cheque / DD : Please make all cheques_ / DDs payable to “Indian Association”. Outstation bank charges are an Pharmaceutical additional Rs. 30.

Card : _____
Total charge : _____
Name on card : _____
Card Type : _____
Card No. : _____
Expiry date : _____
(dd / mm / yy)
Authorised signature : _____

If paying with a credit card, you can also fax the filled forms to 91 22 26670744.

Send the completed membership application forms to

The Secretary,
Indian Pharmaceutical Association,
Kalina, Santacruz (East), Mumbai – 400 098,
Maharashtra, India.