



**TRI-STATE ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN**

**MEMBERSHIP APPLICATION**

MEMBER'S NAME: \_\_\_\_\_

NAME OF SPOUSE: \_\_\_\_\_

PREFERRED MAILING ADDRESS: \_\_\_\_\_

TELEPHONE HOME: \_\_\_\_\_ OFFICE: \_\_\_\_\_

FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

MEDICAL SCHOOL: \_\_\_\_\_

YEAR OF GRADUATION \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

HOBBIES / INTEREST / SPORTS: \_\_\_\_\_

CHILDREN'S NAMES: \_\_\_\_\_

NEW MEMBER: \_\_\_\_\_ RENEWAL: \_\_\_\_\_

TAPI LIFETIME MEMBERSHIP: \$250.00 YES \_\_\_\_ NO \_\_\_\_

TAPI ANNUAL DUES: \$ 50.00 \_\_\_\_

MEMBERSHIP YEAR EFFECTIVE FROM JULY 1ST TO JUNE 30TH

Check payable to: *TAPI*

**MAIL TO:**

TAPI

P.O.Box 672

Monroeville, Pa 15146