



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

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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- Annual membership Rs. 150
- 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 Pharmaceutical Association”. Outstation bank charges are an 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.