Society for Bacteriophage Research and Therapy (SBRT)

Membership Application Form

A. Personal / Professional / Academic Details

Name: Dr./Prof. (In capital letters): ……

Designation & Organization: ……

Qualification & Area(s) of Specialization: ……

……

Professional Experience (Years): …… Nationality: ……

Corresponding Address: ……..

Contact Number: …… Email ID: ……

B. Select Membership Category

	Student	Faculty	Corporate
1 Year	500	1250/-	1500/-
2 Year	900	2250/-	2700/-
5 Year	Not permitted	4500/-	5400/-
Life member	Not permitted	6000/-	12000/-

C. Payment Details

Membership Fee: ₹ / USD _____

Mode of Payment: ☐ Online Transfer ☐ UPI / Net Banking ☐ Demand Draft / Cheque

Transaction / DD Number: …… Date of Payment: …….

Bank Name: …… Attach Payment Receipt / Screenshot: ……..

D. Declaration

I hereby declare that the information provided above is true to the best of my knowledge. I agree to abide by the rules and regulations of the Society for Bacteriophage Research and Therapy (SBRT).

Date: …….

Place: ..…… Signature of Applicant

E. For Office Use Only

Membership No.: Approved as:

Date of Approval: Receipt No.:

Signature of Secretary / Treasurer