KENYA ORTHOPAEDIC ASSOCIATION
NEW DOCTORS PLAZA
THE NAIROBI HOSPITAL
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MEMBERSHIP APPLICATION FORM

Name Prof/Dr/Mr/Mrs/Miss_____

Date of Birth (DD/MM/YYYY)_____/_____/_____ MP&DB Number _____

Category of Membership _____

Postal Address _____ Code_____ City_____

Telephone (Office) _____ Mobile _____

Email Address _____

Academic Qualifications _____

Areas of Sub Specialisation _____

Area of Practice (Institution, City, Country) _____

Referees (Name, Institution, City Country)

1. _____
2. _____

_____ _____

Signature Date

Please attach certified copies of all the relevant academic documents and your registration certificates from the Medical Board. This form should be accompanied with Kshs. 5000 for Surgeons and Kshs. 3000 for Associates. Referees must be Fellows or Members of KOA.