



# Ceylon College of Physicians

341/1, Kotte Road, Rajagiriya.  
Tel: +94 11 2888146 & +94 11 5754250 Fax: +94 11 2888119 E-mail: [ccp@eureka.lk](mailto:ccp@eureka.lk)  
Website: [www.ceycolphysicians.org](http://www.ceycolphysicians.org)

## Membership Application Form

I wish to apply for Life Membership of the Ceylon College of Physicians

Applicant's Surname: \_\_\_\_\_

Other Names: \_\_\_\_\_

Address: \_\_\_\_\_

Residence: \_\_\_\_\_

Hospital / Faculty \_\_\_\_\_

Telephone: \_\_\_\_\_

Residence: \_\_\_\_\_

Hospital / Faculty \_\_\_\_\_

Cellular No: \_\_\_\_\_

E-mail : \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Civil Status: \_\_\_\_\_

Sex: F/M \_\_\_\_\_

Qualifications: \_\_\_\_\_

MBBS/ Year \_\_\_\_\_

MD/Year \_\_\_\_\_

OTHERS/Year \_\_\_\_\_

(Submit documentary evidence of your medical qualifications with copies of certificates and a short CV)

I certify that I shall not misuse my membership status in the CCP contrary to SLMC regulations.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

I declare that the candidate is known to me and that the information presented herein is accurate. I am not aware of any disciplinary or professional conduct issues that might affect the candidate's suitability as a COLLEGE member.

Proposed by: \_\_\_\_\_

Signature: \_\_\_\_\_

I declare that the candidate is known to me and that the information presented herein is accurate. I am not aware of any disciplinary or professional conduct issues that might affect the candidate's suitability as a COLLEGE member.

Seconded by: \_\_\_\_\_

Signature: \_\_\_\_\_

Proposer and Seconder should be Members of the Ceylon College of Physicians

Life Membership fee: Rs. 5,000.00

Cheque should be drawn in favour of "Ceylon College of Physicians" and crossed A/c payee only

**Office use only**

**Membership No**

Paid in cash / cheque: Rs.....

Receipt number & date .....

The Council accepted the application on .....

Signature: \_\_\_\_\_

President / Secretary