Allahabad Nursing Homes & Pvt. Doctors Welfare Association

Membership Form

Session Year : ....

Date : ....

Hospital Name :..
Address :..
:..
:..
CMO Registration No. :..
Establishment Year :..
Registered Consultant :.. Qualification :.......................................
Mobile No. :... E-mail ....
Name of Owner :.. Qualification :.......................................
DOB : .... Mobile No.:................................ Owner's E-mail ....
OPD Timing :... Bed Capacity ....
Hospital's Special Facility :..
Hospital Manager's Name :.. Mobile No. ....

Personal Details (Optional)

Spouse Name :.. DOB: .... Marriage Anniversary :.....................

Male	Date of Birth	Female	Date of Birth

I hereby pledge that the information give above is true to the best of my knowledge.

Consultant/Owner Signature

FOR OFFICE USE ONLY

Membership Regd. No. : ....

Collection Date : ....

PAYMENT DETAILS

Receipt No.	Bank/Branch	Amount (Rs.)	Cash / Cheque No. / D.D. / UPI	Date

Annexure

1. Photo of Owner
2. CMO Registration Certificate Photocopy.
3. Cheque/Draftshould be in favour of
   A/c Name **"Allahabad Nursing Homes & Pvt. Doctors Welfare Association".**

Collected by