Indian Medical Association of Acupteesure

An Organ of Swasthya Jagarukata Mission

R.O. : Narayan Bhawan, East Lohanipur, Patna-3
D.O. : Munirka, New Delhi-67

Membership Form

Form No ....

1. Name in full (Block Letters) : ....
2. Father's/ Husband's Name : ....
3. Date of Birth : .... 4. Qualification : ....
5. Permanent Address : ....

   ....

   ....

6. Correspondence Address : ....

   ....

   ....

DECLARATION OF THE APPLICANT

The contents of the Membership form that I have submitted are true to the best of my knowledge. If any statement given by me as above is proved to be false, I will be responsible and liable to be punished.

(Signature of the Applicant)

For Office Use Only

Accepted/Rejected

Incharge

Dated ....

Seal