INDIAN MEDICAL ASSOCIATION
HOSPITAL BOARD OF INDIA

Madhya Pradesh State Chapter

IMA House, Wright Town, Jabalpur, 482002,
Ph. 0761- 2404940, Email imampstate@yahoo.co.in

APPLICATION FORM FOR ENROLMENT AS MEMBER

1. Name of Nursing Home/ Hospital : ______________________________
2. Contact Details
   - Address : ______________________________
   - City : ____________________ Pin Code ____________
   - Phone No. : ____________________ Tele Fax No. ____________
   - E mail : ____________________ Web site ____________

3. a Status of Nursing Home/ Hospital (tick whatever applicable) : Proprietorship Firm / Partnership Firm / Private Limited Company / Public Limited Company / Registered Charitable Trust

3. b Registered with Firm & societies : Yes / No
   - If yes Registration No. : ______________________________
   - Date of Incorporation : / /

3. c Registration No of Nursing Home/ Hospital Under the Act : NUMBER ____________ VALID UP TO / /

3. d Name of the Registering Authority : ______________________________

4. Name / Names of Owner / Partners / Directors/ Trusties :
   1 ______________________________
   2 ______________________________
   3 ______________________________
   4 ______________________________

5. a Details of the Nursing Home / Hospital (tick whatever applicable) : Single Specialty / Multispecialty Set up
   : Primary / Secondary / Tertiary Care Set up
   - Number of Beds :
   - Number of Specialists :
   - Number of G D M Os :
   - Number of Para Medical :
   - Number of Non Medical :

5. b Name & Details of Manager / Key person to be contacted :
   - Name : ______________________________
   - Mbl. No. ______________________________
   - Ph. No. ______________________________
   - E mail ______________________________

6. Name of Doctor Representing the Nursing Home / Hospital as Member of IMA HBOI (He/ She Should be a life member of IMA) :
   - Name : ______________________________
   - Designation: ______________________________
   - Mbl. No.: ______________________________
   - E mail : ______________________________
   - IMA Mem. No. :______________________________
   - Branch Name :______________________________

7. Name of Alternate/ Associate Member {Max. 3 Name} (He/ She Should be a life member of IMA) **1.** :
   - Name : ______________________________
   - Designation: ______________________________
   - Mbl. No. : ______________________________
   - E mail : ______________________________
   - IMA Mem. No. :______________________________
   - Branch Name : ______________________________

2. : Name : ______________________________
: Designation: ______________________________
: Mbl. No. : ______________________________
: E mail : ______________________________
: IMA Mem. No. :______________________________
: Branch Name : ______________________________

3. : Name : ______________________________
: Designation: ______________________________
: Mbl. No. : ______________________________
: E mail : ______________________________
: IMA Mem. No. :______________________________
: Branch Name : ______________________________

Place : Signature
Date : Name & Designation of Applicant Member

Fix seal of Nursing Home / Hospital

DECLARATION

I hereby declare that the information given above, to the best of my knowledge and belief, is true and correct.

I hereby declare that I as a representative member and my / our establishment will abide by the Rules, By laws and guidelines given by the IMA Hospital board of India.

Place : Signature
Date : Name & Designation of Applicant Member

Fix seal of Nursing Home / Hospital

Forwarding Note by Secretary of Local Branch of IMA, MP State

I have verified the record and found that Dr. ________________________ is a Life Member of ________________ Branch. The application is recommended for enrolment as member of IMA HBI.

Place : Signature
Date : Name of the Local Branch Secretary

Fix seal of Local Branch If IMA

NOTE: The required Five year Membership Fee of Rs. One Thousand, by demand draft in favor of IMA, MP State, and three Passport size photos of the Applicant Member to be enclosed along with this application form