INDIAN MEDICAL ASSOCIATION KERALA STATE BRANCH

 PATIENT CARE SCHEME

 MEMBERSHIP APPLICATION FORM- 2021-22

Proposed by………………………………………….......................Branch…………………………………………………………………..

Name………………………………………………………………………..Branch…………………………………………………………………

Address……………………………………………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………………………………………………

Email……………………………………………………………………… Mob.no……………………………………………………………

IMA Life Membership No…………………………………………………………………………….

KSMC Reg.No…………………………………………………………………………….

Amount Paid…………………………………………Route of Payment……………………………………………………………

(To be renewed every 3 years by making the payment of Rs.1000/)

Charity Activities the proposed member is interested in………………………………………………………………………..

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…………………………………………………………………………………………………………………………………………………………………

Place……………………………………… Date………………………………………….

 Signature…………………………….. Name…………………………………..

Date…………………………..