



MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA
INDIAN MEDICAL ASSOCIATION

MEMBERSHIP APPLICATION FORM

Name: _____
 Address: _____
 City: _____ State: _____ Pin: _____

Sl. No.	Name of the Institution	Address	City	State	Pin
1.					
2.					
3.					
4.					
5.					

Signature of Applicant: _____
 Date: _____

Signature of Secretary: _____
 Date: _____