

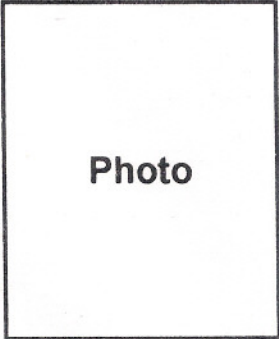
Indian Medical Association of Acupressure

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