

RAJKOT INDIAN MEDICAL ASSOCIATION

Personal Information Performa
(Kindly complete the form in CAPITAL letters)

NAME : DR. _____
(Surname) (Name) (Father's / Husband's Name)

QUALIFICATION : _____

SPECIALITY : _____

MEDICAL COUNCIL REGISTRATION NUMBERS :

MBBS _____ DIPLOMA _____ MD/MS _____ MCh/DM/DNB _____

IMA LIFE MEMBERSHI NUMBER (HQ) : GUJ/ _____

IMA GSB NUMBER (AHMEDABAD) : _____

NSS NO: _____ SSS NO: _____ PPS NO: _____ Health Scheme No: _____

RESIDENCE ADDRESS: _____

CLINIC / HOSPITAL ADDRESS: _____

PHONE NO (C) _____ (R) _____ (M) _____

EMAIL ID _____ FAX NO. _____

DEGREE	NAME OF COLLEGE	NAME OF UNIVERSITY	PASSING YEAR
LCPS/LMP			
MBBS			
DIPLOMA			
MD / MS			
MCh / DM			
DNB			

BLOOD GROUP: _____ Rh _____ DATE OF BIRTH ___/___/___

COUPLE / SINGLE MEMBERSHIP : _____ PRIVATE PRACTICE SINCE: ___/___/___

GOVERNMENT SERVICE ___/___/___

SIGNATURE: _____ RUBBER STAMP