



INDIAN HOMOEOPATHIC MEDICAL ASSOCIATION

I H M A

Reg. No: 64/04. Reg. Office: 1/4741, P.O. Eranhipalam, Kozhikode-673006, Kerala, India

Web: www.ihma.org.in E-mail: info@ihma.org.in

MEMBERSHIP APPLICATION FORM (Please fill in block letters)

paste unsigned PP size Photo here

1. Full Name with Initials

2. (a) Date of Birth DD MM YY YY (b) Sex (M/F) (c) Blood Group Rh ve

3. Father's/Husband's Name

4. Educational Qualifications

Qualification	University/ Board	Year of passing	Class Obtained
General			
Professional			

5. (i) Medical Council Reg. No. Part Homoeopathy

(ii) Name of Medical Council

6. (i) Address for Communication

(ii) Permanent Address

Pincode

Pincode

7. Telephone (with ISD/NSD code)

Clinic
Residence
Mobile

8. Email

9. If employed, give Details:

10. Are you a member of any other organization/association, specify details:

11. Membership requested: Ordinary Life Associated (please tick)

12. Academic excellence/achivements/field of interests, if any.

13. Details of fee remitted:

I Dr. _____ solemnly declare that the

information given above is true to the best of my knowledge and belief, kindly enroll me as a member of Indian Homoeopathic Medical Association and if enrolled as requested, I shall remit all the dues as may be prescribed from time to time and will obey the rules and regulations of the association as are enforced or amended from time to time. I also solemnly declare that I am not having membership in any other professional organization of homoeopathic field constituted in India except service cadre, PG/Interns association or research body.

Date

Signature

For Office Use Only

Membership Id:

Fee Collected: Cash MO DD Amount (Euro/Rs)

Date of enrollment: DD MM YY YY

Secretary General - IHMA