

## DECLARATION

[Please fill up in BLOCK CAPITALS]

I, ... .., Proprietor / Director /  
Representative of ... .. Hospital / Nursing  
Home / Institution, with address - ... ..  
... ..,

hereby give my consent to become MEMBER of the ALL ODISHA PRIVATE  
MEDICAL ESTABLISHMENT FORUM, which has been constituted for  
providing better health care facility and redressal of grievances.

FURTHER, I agree to actively participate and be abided by all the Resolutions /  
Decisions taken in this regard by the above Forum.

(Signature)

Name-

Hospital/Nursing Home/ Institution _____
Registration No. _____/ year _____
Address- _____
Mobile No. _____
Land Phone No. _____
e-Mail ID _____

**AOPMEF Receipt** No. / dated amounting to Rs. 2000/- / Rs. 7000/-  
[**Membership Fees:** Rs. 2000/+ Corpus Fund Dues: Rs. 5000/-]

**or**

**CASH TRASFER:** ANDHRA BANK KHANDAGIRI; ACCOUNT NO – **148010100058864**;  
IFSC CODE: ANDB0001480 → Amount- Date of Transfer receipt no.