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**

**(For Cheque or Transfer)**

**NAME OF ACCOUNT IN BANK –** All Odisha Private Medical Establishment Forum (AOPMEF)

**CASH TRASFER**: ANDHRA BANK KHANDAGIRI; ACCOUNT NO – **148010100058864;**

IFSC CODE: ANDB0001480 🡪 Amount- Date of Transfer receipt no.