MEMBERSHIP FORM
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____

PAYMENT PARTICULARS:

AOPMEF Receipt No. / dated amounting to Rs. 2000/- / Rs. 7000/-

[**Membership Fees:** Rs. 2000/+ Corpus Fund Dues: Rs. 5000/-]

Or

NAME OF ACCOUNT IN BANK – All Odisha Private Medical Establishment Forum

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

IFSC CODE: UBIN0814806 → Amount- Date of Transfer receipt no.