MEDINS LEGAL

PHOTO

LEGAL AID FOR MEDICAL PROFESSIONALS

MEMBERSHIP REGISTRATION FORM

Date- ☐☐ ☐☐ ☐☐☐☐

PARTICULARS-

Full Name-_____

M/s/ Dr.-_____

Father's/Husband's/Owner's Name-_____

Contact Number-_____ Alternate Contact Number-_____

E-mail Id-_____ Date of Birth (DD/MM/YYYY)-_____

Name of Clinic/Nursing Home/Hospital/Lab-_____

Address-_____

PIN-_____ City-_____ State-_____

Qualification-_____

Name of the Association enrolled if any-_____

Medical Registration Number-_____

Existing policy or membership with any insurance company (Yes/No) (If yes, name of the insurance policy-_____

Sum insured-_____ Any claim experience-_____

Any claim experience -If yes; please share the brief description about the nature and stage of litigation (this detail is required if you wish to have our membership for non-medico legal cases as well)- _____

_____

If you wish to take membership for any colleague doctor operating from your clinic, please share his/her name with educational qualification-_____

_____

If you wish to have membership for any other qualifiedstaff/nurse/compounder/health worker working in your clinic? If yes, please share the details-_____

_____

Nominee- _____

Any other information- _____

PAYMENT DETAILS-

DATE	DRAWN ON	CHEQUE NO./DD/NO	AMOUNT	NOTES

As per Services of Medins Legal I hereby voluntarily declare to be a member of Medins Legal for which I deposit Rs. _____ for _____ year/s and I am quoting my details above.