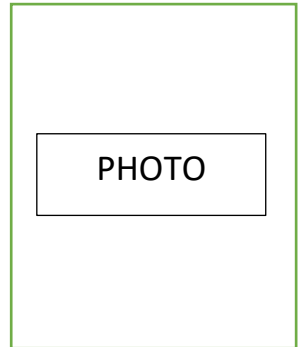


MEDINS LEGAL



LEGAL AID FOR MEDICAL PROFESSIONALS

MEMBERSHIP REGISTRATION FORM

Date-

PARTICULARS-

Name of the Attendant- _____

Name of the Nursing Home/Hospital - _____

Address of the Nursing Home/Hospital - _____

PIN- _____ City- _____ State- _____

E-mail Id- _____ Contact Details- _____

Whether registered with Delhi Nursing Council- _____

Year of Registration- _____

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

Name of Policy- _____ Sum insured- _____ Any claim experience- _____

Any pendency or litigation relating to medical or personal- _____

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/ please share their name with educational qualification- _____

If you get the membership for any other qualified Staff/Lab Technician. If yes, please share the details-

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.

Date:

Place: