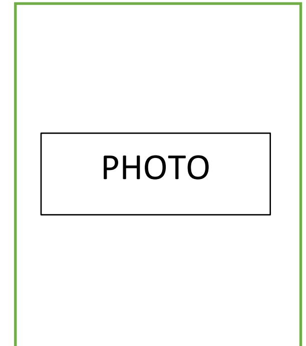
MEDINS LEGAL



LEGAL AID FOR MEDICAL PROFESSIONALS

MEMBERSHIP REGISTRATION FORM

Date- ☐☐ ☐☐ ☐☐☐☐

PARTICULARS-

Name of Medical Director/Owner/Partner- ____________________

Name of the Hospital/ Nursing Home – ____________________

Address of the Hospital/ Nursing Home- ____________________

PIN- __________ City- __________ State- ____________________

E-mail Id- ____________________ Contact Details- ____________________

Year of Establishment- ____________________

Number of Hospital Staff/ General Physicians/ Nurses/ Workers- ____________________

Number of beds- ____________________ Number of ICU beds- ____________________

State in which Hospital/ Nursing Home is registered accredited by- ____________________

Facility for international patients? – ____________________

Approximate number of in-patients/OPD/ Admitted Patients/ Surgeries in last six months- __________

Are the Doctors/Nurses/Technicians working for you-?

- Duly licensed in accordance with the Medical acts of and other prevalent laws- __________
- Members of Medical Association/Council- __________

Specify all the facilities available-

- X-Ray, Scanning, Pathology - ___________
- Whether persons operating these are qualified - _____________

State the number of employees (including visiting Doctors) in act of following classifications)

1. General Physician	Specialist including-
2. Plastic Surgeon	EYE/ENT
3. Dentists	Pathologist
4. Pharmacists	Cardiologist
5. Technician	Radiologist
6. Nurses	Anaesthetists
7. Trainees	Gynaecologist
8. Voluntarily Worker	Dental Surgeon
9. Other, Please specify	Paediatrician

Ambulance facility available- ________________

Facility for international patients? – ________________

Whether food is supplied by you to the patients? If yes, specify whether it is prepared by you of supplied by outsiders. If supplied by you, Please specify the measures taken for maintenance of kitchen and other supervisory measures. ____

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Do you supply medicines to the patients? ____

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)-

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If you wish to take membership for any colleague doctor/ operating from Nursing Homes/ Hospitals, please share their name with educational qualification- ______________________________

If you get the membership for any other qualified Staff/Nurse/Compounder/Health Worker working in your Nursing Home/ Hospitals? If yes, please share the details-

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: