Karnataka Qualified Homoeopathic Doctors Association®

Richmond Plaza, Raja Ram Mohan Roy Road, Richmond Circle, Bangalore 560025
Website: www.kqhda.webs.com
Phone: 080 - 2337 1015 Email: kqhda1992@gmail.com

MEMBERSHIP APPLICATION FORM

LIFE MEMBER / ASSOCIATE MEMBER

Membership proposed by:

REQUEST

To,
The Secretary, KQHDA
Bangalore

Dear Sir,

I hereby apply to be enrolled as a member of the Karnataka Qualified Homoeopathic Doctors Association® as Life-Member / Associate-Member by paying the below amount.

Please affix a recent Passport Size Photo

Amount Paid:	In Words:

APPLICANT INFORMATION

Name:		
Date of birth:		
Father's/Husband's Name:		
Address (Permanent/Correspondence):		
City:	State:	Pin Code:
Mobile:	Telephone:	

CLINIC/HOSPITAL INFORMATION

Address:		
City:	State:	Pin Code:
Phone & Email:		

QUALIFICATION

Qualification	College	University

REGISTRATION DETAILS

Registration No. of CCH/State Homoeopathic Board/Council:
Date:

DECLARATION

I declare that I am registered with CCH/State Homoeopathic Board/Council. I certify that all the details/ documents furnished by me are true. If my statement is found to be incorrect, my membership would stand to be cancelled and the fee paid by me will be liable to be forfeited by the association. I hereby give undertaking that I shall abide by the Rules and Regulations of KQHDA.

Date:	
Place:	Signature of applicant