

**Karnataka Qualified Homoeopathic Doctors Association®**

Richmond Plaza, Raja Ram Mohan Roy Road, Richmond Circle, Bangalore 560025

Website: [www.kqhda.com](http://www.kqhda.com) Email Address: kqhda1992@gmail.com

| Membership Application form |
| --- |
| Life member / Associate member |
| Membership proposed by:  |
| Request |
| To, Attach recent Passport Size PhotoThe 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. |
| Amount Paid:**5000/=**   | **In Words: Rupees Five Thousand Only** |
| 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 ID: |
| QUALIFICATION |
| Qualification | College | University |
|  |  |  |
| Registration details |
| Registration No. of CCH/State Homoeopathic Board/Council:  |
| Date of Medical Registration:  |
| 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: |