INDIAN MEDICAL ASSOCIATON

A.P.STATE Private Medical establishments Board

(ANDHRAPRADESH)

APPLICATION FOR ENROLLMENT

(To be filled in BLOCK LETTERS only)

---

1. Name & Address of the Hospital **(including mobile, email id):**

2. Status (Strike off whichever is not applicable) & year of establishment: :

Proprietorship firm / Partnership firm / Private Limited Company / Public Limited Company.

3. Bed Strength and name of the sophisticated equipment you have)

4. Representing Doctor's Name & designation & reg.no
(Should be the Proprietor (or) a partner (or) a member of the board of Directors of the Hospital and should also be a Life Member of IMA)

5. Name of the IMA Branch in which the representing Doctor is a Life Member:

6. Weather the establishment registered with DM&HO or not? if yes, HOSPITAL Reg.no :

7. Weather the establishment has authorization from biomedical waste authorities?

8. If you have u-scan, is it registered under PC-PNDT ACT?

9. Have you or your hospital covered under professional indemnity insurance?

10. Number & description of staff you have:

DECLARATION

I hereby declare that my / our establishment will abide by the guidelines given by the Private medical establishments Board of IMA now and then which is a basic qualification for enrollment in the Board.

I am also aware that the decisions of the State Council of IMA A.P. State Branch are final with regard to any matter concerned with the Private Hospitals Board of IMA A.P. STATE. I am also aware that Special contribution can be raised at the time of need as decided by the managing committee of PMB /SWC / COUNCIL of IMA-A.P. STATE

SEAL OF THE HOSPITAL **SIGNATURE OF THE REPRESENTING DOCTOR.**

NOTE :.

The enrollment fee will have to be paid by Demand Draft drawn in favor of "IMA PMB FUND ACCOUNT" as per guide lines and should be sent along with this application form.

Send the filled up application along with DD to:
SECRETARY -IMA PMB ,101-IMA BUILDING, KOTI,SULTAN BAJAAR, HYDERABAD

To be filled in by the IMA Branch in which representing Doctor is a Life Member.

The above statements made by the applicant have been verified to be true and is being recommended for enrollment in the Private medical establishments Board of IMA- A.P.state.

SIGNATURE OF THE PRESIDENT/ SECRETARY of the local IMA branch

SEAL OF THE local IMA BRANCH .

FOR PMB OFFICE PURPOSE:

Application& Reg.fee RECEIVED ON: ______________________

Issued ENROLLMENT NO: ________________________________

DETAILS REGARDING ENROLLMENT FEE : D.D.no: Bank name:

Any other remarks:

AUTHORISED SIGNATURE &SEAL OF PMB ______________________________

Enrolment or Registration fee:

Clinics	Below 20 beds	20 to 50 beds	Above 50 beds.	labs	radiology
100/-	200/-	300/-	1000/-	200/-	300/-

Please note:
1.The reg.fee may be enhanced by the recommendation and ratification of PMB managing committee, state working committee and state council of IMA-A.P. state.
2. Use separate paper for any extra details