

# PROFESSIONAL PROTECTION LINKED SOCIAL SECURITY SCHEME



## OF IMA TAMILNADU



### MEMBERSHIP APPLICATION FORM

(Please write Legibly) Date of Despatch Details : Date : .....

1. Name (in Capital Letters) : \_\_\_\_\_
2. Date of Birth : \_\_\_\_\_ Age: \_\_\_\_\_ Sex : Male / Female
3. Father's / Husband's Name : \_\_\_\_\_
4. Address : \_\_\_\_\_

Pincode: \_\_\_\_\_  
 Telephone No. : \_\_\_\_\_

5. Telephone No. : \_\_\_\_\_ Resi. \_\_\_\_\_ Hosp.: \_\_\_\_\_ STD Code : \_\_\_\_\_
6. Qualification : \_\_\_\_\_ Name of University : \_\_\_\_\_ Year of Passing : \_\_\_\_\_

7. Registration No. : \_\_\_\_\_ Year of Registration : \_\_\_\_\_
- Name of Medical Council : \_\_\_\_\_
8. Present Places of Practice : \_\_\_\_\_
9. IMA Life Membership No. : \_\_\_\_\_
10. Name of Local Branch : \_\_\_\_\_
11. Category Applied : GP / Non Surgical Specialist / Surgical & Anaesthetist
12. Are you insured under Indemnity Scheme : Yes / No

If Yes, Name of Insurance Company: \_\_\_\_\_  
 Place : \_\_\_\_\_ Policy No. : \_\_\_\_\_ Date of Expiry : \_\_\_\_\_

13. Name of Family Members	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Nominee's Name : \_\_\_\_\_ Age : \_\_\_\_\_ Sex : \_\_\_\_\_ Relationship : \_\_\_\_\_