KOLHAPUR MEDICAL ASSOCIATION

MEMBER'S CARD

Dear Members,

Please fill this form and return to the person at K. M. A. Hall or any of the Exe. Member. This is needed to update your information on computer. Please return this form within a week of receipt.

Couple members please XEROX the form & use.

Member's Name :
(Surname First)

Membership Category : Annual / Life, Single / Couple, IMA / KMA / Associate, Hon. Senior
(Please Tick Mark)

Birth Date :

Marrital status ☑ Married ○ Unmarried Anniv Date :

Residance Address : Phone :

Mobile :

E-Mail :

Town / Area

Educational Details :

Sr. No.	Degree / Diploma	College/Institution	University	Year of Pasing
1.				
2.				
3.				
4.				
5.				

Practicing Speciality :
(If more then one Speciality Qualifications)

M.M.C. Reg. No. : Year :

Hospital Address . Phone :

Fax :

E-mail :

Web-site

Town/Area

Consulting Phone :
Room Address

Town/Area

Mailing Address ◯ Residance ◯ Hospital ◯ Consulting Room
(Tick only one)

Mailing Type ◯ Normal ◯ E-mail

Membership of (any other) Local Medical Organization Society
1. _____
2. _____
3. _____
4. _____

Hobbies (In order of Priority) 1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Social Secutiry
Scheme Details

Other Information

Signature :

Date :