NATIONAL INTEGRATED MEDICAL ASSOCIATION, JALANDHAR

AFFIX RECENT PHOTOGRAPH

1. Name: _____
2. Regd. No.: _____
3. Qualification: _____
4. Address:
   - Residence _____
     _____
     _____
   - Clinic _____
     _____
     _____
5. Date of Birth: _____
6. Date of Marriage: _____
7. Contact Information
   - Ph. Clinic _____
   - Ph. Residence _____
   - Mobile _____
   - E-mail Id _____
8. Institution From where Passed:_____
   _____
9. Year of Passing: _____
10. BLOOD GROUP: _____

IMPORTANT:

- Please Fill the form In block Letters
- Please fill the correct spellings to avoid errors during printing.
- Affix Recent Passport Size Photograph
- Submit Completed form to any of the NIMA office bearer.