ALLAHABAD MEDICAL ASSOCIATION

(BRANCH OF IMA)

FULL NAME:

MCI REGISTRATION No.	BLOOD GROUP / DATE OF BIRTH / **Photo**
SPOUSE NAME	
Date and month of birth	Wedding Anniversary
CHILD'S FIRST NAME	DATE OF BIRTH
1	
2	
3	
4	
RESIDENTIAL ADDRESS:	
PROFESSIONAL ADDRESS ☐ HOSPITAL ☐ CLINIC ☐ CGHS ☐ RAILWAYS ☐ UPPMHS Please tick (√) ☐ OTHER (Please specify)	
COLLEGE AND YEAR OF ADMISSION	
MBBS	
PG	
M.Ch/D.M.	
FIELD OF SPECIALIZATION	
Mobile No.	**WHATSAPP NO.**
EMAIL:	
IMA MEMBERSHIP NO.	
Any other AMA member in the family.	
Name	
Relation	

PLEASE FURNISH DETAILS IN CAPITAL LETTERS AND SEND IT ALONG WITH YOUR PHOTO on Email: amaprayagraj@gmail.com