HOSPITAL PROTECTION SCHEME

OF PPLSSS OF IMA TAMILNADU

MEMBERSHIP APPLICATION FORM

1. Name of Hospital (in Capital Letters) : _____
2. Date of Establishment : _____
3. Address : _____

_____

_____

_____ Pin code: _____

Telephone Nos. : _____ STD Code: _____

E-mail : _____ Fax No : _____

4. IMA NHB No. : _____
5. Year of Enrolment : _____
6. Owner's / Managing Directors Name : _____
7. IMA Local Branch Name : _____
8. IMA Life Membership No : _____
9. IMA PPLSSS No. : _____

Name of the Medical Council : _____

10. Category Applied : Primary Level / Secondary Level / Tertiary Level
11. Are you insured under indemnity Scheme : Yes / No

If Yes, Name of the Insurance Company : _____

Place: _____ Policy No: _____ Date of Expiry: _____

FACILITIES AVAILABLE

12. Total No. of Beds : _____ General Wards : _____ Rooms : _____
13. ICU : Yes / No ICCU : Yes / No IMCU : Yes / No
14. O.T. : Yes / No if Yes No. of O.T : _____
15. Labour Room : Yes / No Laboratory : Yes / No X-Ray : Yes / No
16. Ultra Sound : Yes / No Physiotherapy : Yes / No

STAFF PATTERN

17. No. of Consultants : _____
18. No. of Duty Doctors : _____
19. No. of Staff Nurses : _____ Qualified : _____ Trained : _____
20. No. of Technicians : _____ Qualified : _____ Trained : _____

21. Payment Details :

DD No. _____ Bank _____ Branch _____

Amount _____ Date of Issue _____

Payment options DD

DD should be send in the name of "**HPS of PPLSSS of IMA TN**" Payable **at Kallakurichi**

Send the filled up application along with payment information

DR.S.Nehru, MS.,DO., Hony.Secretary, PPLSSS of IMA TN..

Hi-Tech Eye Care Hospital, Chekku Mettu Street, Kallakurichi - 606202, Villuppuram District.

Mob: 9487272627 Ph: 04151- 224176

Despatch Details : Date _____ Courier/Registered Post/ in person

Date of commencement of membership will be from the date of receipt of DD at the principal office.

DECLARATION

I, _____ _____a Life Member of _____ Branch of IMA, do hereby, declare that the details furnished above are true and correct and that I will abide by the Rules and Regulations of Professional Protection Linked Social Security Scheme of IMA Tamilnadu as amended on 01.3.1998.

Date: Signature

Not For Renewal Members

Forwarded: _____

Designation: _____

(To be forwarded by the local branch President/Secretary/PPLSSS District Co-ordinator)

Signature: _____

(FOR OFFICE USE ONLY)

Date of Receipt :

Mode of Receipt : Courier/ Reg.Post /in person (Time: a.m/p.m)

Application Form : Complete/ Incomplete Remarks:

D.D. Realised on :

Date of Commencement of Membership :

Date of Despatch of Receipt to the Hospital/Nursing Home :

Date of Despatch of Certificate to the Hospital/Nursing Home :

HPS Membership No :

VRenewal Due on :

Letter of reminder sent on :

Renewal Fee received on :