Regd. No. 03130

Indian Allied Health Association (IAHA)

(Constituted under the Indian Societies Registration Act, 1860)

645B/232, A-CC, Opp. Ram Kishor Convent Inter College, Abhishekpuram,
Jankipuram Extn., Lucknow-226021

MEMBERSHIP APPLICATION FORM

No.

To,

The Secretary
Indian Allied Health Association
Lucknow (U.P.) India

Branch
.....
.....

Dear Sir/Madam

I request you to enroll me as ..... member of Indian Allied Health Association. I am enclosing / paying Rs..... through - Cash / Cheuqe / D.D. No. ..... of .... bank, dated .....

I am enclosing two copies of passport size photograph and attested Xerox copy of my Aadhar Card. Following are my details :-

Name : Mr./Ms./Mrs./Dr./Prof./ Org./Inst. .....

Father / Spouse Name : .....

Qualification : .....

Date of Birth : .....(DD/MM/YYYY) Gender .....(M/F)

Address .....

.....

..... Ph. .....Mob. .....

Proof of ID : PAN Card No. (Person/Org./Inst.) .....

Adhard Card No. .....

Email : .....

Membership Category : (Please tick appropriate box) :

S.No.	Membership Type	Fees in INR	Application Processing Fee	Tick Box
1.	Institution Membership (IM) Annual	10000.00	250.00	☐
2.	Paramedics Membership (PM) Annual	2000.00	250.00	☐
3.	Student Membership (SM) Annual	1000.00	250.00	☐
4.	Associate Membership (AM) Annual	1000.00	250.00	☐
5.	Patron Annual	25000.00	250.00	☐

DECLARATION

I hereby certify that the above information is correct and complete. If any information given is incorrect, I would be responsible for it.

Date : .....

Place : .....

.....

SIGNATURE OF APPLICANT