## MAHARASHTRA COUNCIL OF INDIAN MEDICINE

Aarogya Bhavan, 4<sup>th</sup> Floor, Sent. Jorj Hospital Compound, P. Dimelo Road, Near CST, Mum-400 001. Tel. :- (022) 2261 26 46 / 22 61 82 61

## **APPLICATION FORM FOR I-CARD**

	PHOTO (Please	e fill in the following c			REOFPRACTITION BLOCK LETTER				sing	a <b>BL</b>	ACK	BALL		PHOTO PEN )		)	
1.	Full Name		:-			d		i ≁	j				t ≁		h b		
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2.	Registratior	n No. & Schedule	:-	S	t	а	r	t	i	j	g	wi	t	h	h	h	
3.	Registration	n Date	:-	S	t	а	r	t	i	j	g	w i	t	h	h	h	
4.	Permanent l	Residential Addre	ess :-	S	t	а	r	t	i	j	g	w i	t	h	h	h	
				S	t	а	r	t	i	j	g	w i	t	h	h	h	
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				S	t	а	r	t	i	j	g	w i	t	h	h	h	
				S	t	а	r	t	i	j	g						
5.	Phone No.	with STD Code	:-	S	t	a (STD C	<b>r</b> ode)	t		j	g	w i	t	h	h	h	
6.	Mobile No.		:-	S	t	а	r	t	i	j	g	w i	t	h	h	h	
7.	Date of Birt	th	:-	S	t	а	r	t	i	j	g	wi	t	h	h	h	
8.	Qualificatio	n	:-	S	t	а	r	t	i	j	g	w i	t	h	h	h	
9.	University		:-	S	t	а	r	t	i	j	g	w i	t	h	h	h	
10.	Year of pass	sing degree	:-	S	t	а	r	t	i	j	g	wi	t	h	h	h	
11.	Additional	qualification (if a	ny):-	S	t	а	r	t	i	j	g	w i	t	h	h	h	
12.	University		:-	S	t	а	r	t	i	j	g	w i	t	h	h	h	
13.	Passing Yea	r	:-	S		а	r	t	i	j	g	wi	t	h	h	h	
14.	Blood Grou	ıp	:-	S	t	а	r	t	i	j	g	wi	t	h	h	h	
15.	Signature of	fPractitioner	:-														

Note :- Fees of Rs. 200/- ((Rupees Two Hundred only) if registered before 31<sup>st</sup> December, 2007. Fees of Rs. 300/- (Rupees Three Hundred only) if registered in 2008 & thereafter.

The above form dully filled in the legible hand writting should be sent on the above address along with a cash of Rs. 200/300 as applicable.