



PROFESSIONAL PROTECTION SCHEME OF IMA

KERALA STATE

FORM OF APPLICATION FOR MEMBERSHIP

1. Name & Address in Capital Letters
(with Pin Code)

Age:

Phone No. & (Res:
STD Code (Hosp:
E-mail:

2. Address to which correspondence is to be
made with Pincode & Phone number :

3. Father's/Husband's Name :

4. Qualifications

Name of University

Year of Passing

1.

2.

3.

Any Other

5. Registration No. with name of the
Medical Council & Year of Registration :

6. Name of the institution where you are
working at present :

7. Whether insured with any insurance company
under Indemnity Scheme and if so, give name
of the company, Policy No. & date of expiry :

8. Whether you are a current member of the
IMA and if so, the name of the Branch :

9. Are you a Life Member of IMA and if so,
give the Membership No. :

10. Date of despatch :

DECLARATION

I.....a 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 the
Professional Protection Scheme of IMA, Kerala State, as amended on 27/06/93, 12/11/94, 10/11/96, 22/11/97,
14/11/98 & 27/11/99.

Signature

Date

Name:

CERTIFICATION FROM THE BRANCH PRESIDENT/SECRETARY

I, Dr.....President/Secretary, IMA Branch do hereby certify
that Dr.....is a current Ordinary (Annual)/Life Member of IMA.....Branch

Signature

Date..... (Branch Seal)

President/Secretary, IMA.....Branch

(PTO)

