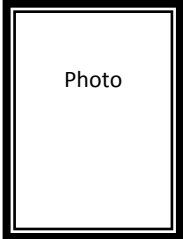




RESEARCH FOUNDATION OF HOSPITAL & HEALTHCARE ADMINISTRATION (RFHHA)

ASSOCIATE/ CORPORATE MEMBERSHIP FORM



Membership No.:

1. **Personal Information (write in block letters)** (Details of contact person in case of corporate membership)

First Name : Middle Name :

Last name : Date of Birth :

Marital Status : Date of Anniversary:

2. **Academic degree(s)** (please mention the year of acquiring the qualification and Institute of passing)

Graduation :

Post graduation :

Higher education / Others :

Higher education / Others:

3. **Name of Company/ Institution/ Currently Employed with:**

4. **Mailing Address:** (please check one) Business Home

Address:

City: Zip / Postal Code:

Country: Tel. No. :

Mobile No. : Email ID. :

5. **I will accept RFHHA communications via email:** Yes No

6. **Please send a copy of the registration to:** Postal Address e mail address

7. Do you prefer your email id to be included in the list that is provided to exhibiting companies.

Yes No

8. Registration fees:

1. Life time Associate membership
Membership fee: 8000 INR or 160 USD

2. Corporate/ Institutional Membership
Membership Fee: 1, 50,000 INR or 3,000 USD

9. Professional information:

Specialty area

- a) Clinician
 - b) Public Health
 - c) Bio Med Eng
 - d) Architect
 - e) Med Informatics
 - f) Nursing
 - g) Pharmacy
 - h) Management
 - i) Others (please specify)
- a) Academic
 - b) Administration
 - c) Corporate/Industry
 - d) Govt./Defence Services
 - e) Hospital
 - f) Managed care
 - g) Private Practice
 - h) Other (please specify)

Working area

10. Payment Information

Registration fees: Membership Dues:

Mode of payment: Details of Cheque/DD:

Credit card details:

(Cheque/Demand Draft must be payable to the **RES FOUN OF HOSP AND HCR ADMN payable at New Delhi.**

Details of NEFT transfer : Kotak Mahindra bank ltd, safdarjung enclave, NewDelhi , Branch code 0175, IFSC code KKBK0000175, Account no. 01750020001979, Acc name : RES FOUN OF HOSP AND HCR ADMN. (At any branch of Kotak Mahindra Bank)

11. **Declaration by members:** All the information filled by me is correct.

Date:

Signature:

.....**For official use only**.....

Details Verified

Recommended

Approved

Not Verified

Not Recommended

Not Approved

(Signature)

Admin Officer, RFHHA

(Signature)

Secretary, RFHHA

(Signature)

President, RFHHA

Remarks (if any)

Send completed membership form to : Dr Shakti Kr Gupta, President RFHHA, HOD Dept of Hosp Adm,
Room No. 6 , All India Institute of Medical Sciences, Anasri Nagar , New Delhi , 110029.