



ASSOCIATION OF MEDICAL CONSULTANTS (MUMBAI)

Societies Regn. Act XXI of 1860 Regn. No. BOM-454/81

GBBCD Public Trust Act. 1950, Regn. No. F - 7373 Bom.

Main Office: 302, The Summit Business Park Premises Chsl,

Opp. PVR Cinema, Andheri (East), Mumbai – 40093

Tel: 26844639 / 26821109 / 49765332 / 43472058 **Mobile:** 9867450066

E-mail: membership@amcmumbai.org **Website:** www.amcmumbai.org

MEMBERSHIP FORM

Name* Dr. _____
NAME FATHERS / HUSBANDS NAME SURNAME

Qualifications* _____ Specialty* _____

Medical Council Reg. No.* _____ MMC Validity Date:* _____ State* _____

Date of Birth* _____ Marriage Date _____ Blood Group* _____
*For Joint Membership

Residential Address:* _____

_____ Pincode* _____

Consulting Address: _____

_____ Pincode _____

*I would like to receive my Courier at:

Residence Consulting Room

Contact No.

Residence _____ Consulting _____ Mobile* _____

E-mail* _____

Proposed by (Name) Dr. _____ Signature _____

Date*: _____ Signature of Applicant*: _____

MEMBERSHIP APPLIED FOR:

- | | |
|--|---------------------------------|
| <input type="checkbox"/> Life Membership | Rs. 8000 + 18% GST = Rs. 9440/- |
| <input type="checkbox"/> Jt. Life Membership | Rs.12000 + 18% GST = Rs.14160/- |
| <input type="checkbox"/> Associate Life Membership | Rs. 8000 + 18% GST = Rs. 9440/- |
| <input type="checkbox"/> Associate Jt. Life Membership | Rs.12000 + 18% GST = Rs.14160/- |

For Office use only:

Receipt No. Date : Membership No.

Date of Joining: _____

Scrutinized and Approved by Dr. _____ Signature _____ Date _____

President

Hon. Secretary

***DOCUMENTS REQUIRED FOR MEMBERSHIP APPROVAL**

- 1) Two Passport size (3x4) Photographs with white background.
- 2) Application form duly filled in completely.
- 3) M.B.B.S Certificate.
- 4) Additional Qualification (Post Graduate) university Certificate.
- 5) MMC Registration Certificate.
- 6) Additional Qualification MMC Certificate.
- 7) MMC Renewal (Please submit your MMC Renewal Certificate every Five years).
- 8) Marriage Certificate for Joint Life Membership or Change in Name.
- 9) Proof of Address (Aadhar Card).
- 10) Proof of Payment.

DO YOU WANT TO ENROLL FOR AMC SCHEMES

- | | |
|--|--|
| <input type="checkbox"/> Professional Indemnity | <input type="checkbox"/> Error & Omission |
| <input type="checkbox"/> Health & Accident | <input type="checkbox"/> Consultants Benevolent Scheme |
| <input type="checkbox"/> Car Insurance | <input type="checkbox"/> Financial OPD |
| <input type="checkbox"/> Network of AMC Hospitals (AMC NoAH) | |

***PAYMENT DETAILS :**

Payment Debit: Cheque/DD NEFT Online Payment

Paid Rs. _____ Ref. No. _____ Date _____

Bank _____ Branch _____

Receipt No. _____ Date _____

CHEQUE TO BE DRAWN IN FAVOUR OF
“ASSOCIATION OF MEDICAL CONSULTANTS, MUMBAI”

Net Banking Details:

ACCOUNT NAME: ASSOCIATION OF MEDICAL CONSULTANTS MUMBAI

ACCOUNT NO: 37486042910

BANK NAME: STATE BANK OF INDIA

BRANCH NAME: ANDHERI EAST

IFSC CODE: SBIN0000539

ACCOUNT TYPE: CURRENT ACCOUNT

AGENT NAME: _____