

**FORM FOR NoAH- AMC**

Passport size  
photo of the  
member

**(1) Details of the member**

Name: Dr (Mr/Mrs/Ms) \_\_\_\_\_  
(Name)  
\_\_\_\_\_  
(Middle name) (Surname)

Date of Birth: \_\_\_\_\_ AMC membership No: \_\_\_\_\_

Residential Address: \_\_\_\_\_

\_\_\_\_\_

Contact no : (M) \_\_\_\_\_ (R) \_\_\_\_\_

Email: \_\_\_\_\_

Educational Qualification: \_\_\_\_\_

MMC Reg No: \_\_\_\_\_

**(2) Details of the healthcare unit**

Name of the healthcare unit: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Contact no: \_\_\_\_\_ Land line: \_\_\_\_\_

Email: \_\_\_\_\_

Website : \_\_\_\_\_

❖ Nursing home reg no: \_\_\_\_\_

❖ MTP Registraton no: \_\_\_\_\_

❖ PNDT Reg No: \_\_\_\_\_

❖ FEQH accreditation -----Yes /No-----minimum/optimum/ excellent

No of bed: \_\_\_\_\_ carpet area in sq feet-----

No of OTs-----

**Facilities: Please Tick:**

Medical  Surgical  ICU  NICU  Obstetric / Gynec

Laboratory  X-ray  CT Scan / MRI

❖ Attach Self attested Xerox copies of respective certificates.

**Details of the other members / partners:**

	<b>Name and address</b>	<b>Contact no</b>	<b>AMC member Yes or No If Y then AMC No:</b>

**I hereby solemnly affirm that all the data provided by me in this form is true to the best of my knowledge.**

**Sign :**

**Name of Member:**

**(Stamp of Hospital)**

**Current Fee structure:**

- a.** The Joining fee would be Rs. 2500 for Nursing Homes & Hospitals having bed capacity of 10 or less. For Nursing homes & hospitals having bed capacity of 11-25 Rs 5000 and 26 -50, the joining fee would be Rs. 7500. More than 50 beds it would be Rs10000.
- b.** The Annual fee would be Rs. 500 for Nursing Homes & Hospitals having bed capacity of 10 or less. For Nursing homes & hospitals having bed capacity of 11-25 the annual fee will be Rs 1000 and for hospitals having beds 26 or more, the annual fee would be Rs.1500 and Rs 2000 for those with more than 50 beds.