



INDIAN ALLIED HEALTH CARE PROFESSIONAL / INSTITUTE ASSOCIATION

Application for the Membership

To,

The President

Indian allied health care professional / institute association

Ch. No. 157/1, Near Laxmi Nagar, Metro Station Gate No 1, Vikas Marg, Delhi-110092

Dear Sir,

I wish to become member of AHA, my particulars are as follows;

1. Name: -
2. Qualifications: -
3. Particulars of training in Hospital/Health Administration:-
4. Professional Experience: -
5. Address (Permanent):-
6. Address (Present):-
7. Type of membership applied for (Tick one)
(a) Life (b) Institutional (c) Associate (d) Student

Note:-

1. A brief bio data may please be attached along with degree/diploma certificate.
2. Photocopy of this application form is also acceptable.