**INDIAN MEDICAL ASSOCIATION–TAMILNADU STATE BRANCH**
**PRIVATE HOSPITALS AND NURSING HOME BOARD**

**APPLICATION FOR CHANGE OF NAME/ADDRESS/PROPRIETORSHIP**
**(To be filled In BLOCK LETTERS only)**

**REGISTRATION DETAILS:**

Name of Health Care Unit :

JM No. :

Address :

City/ Taluk :
District :
PIN :

Doctor's Phone* :
Office mobile :

Email Id :
Website :

**NEWDETAILS:**

Reason for Change :

New Proprietor Name :

New Hospital Name :

New Address :

Doctor's Phone* :
Office Phone :
Email Id
Website

## DECLARATION

I hereby declare that my/our establishment will abide by the guidelines given by the Private Hospitals and Nursing Homes Board of IMA now and then, which is a basic qualification for enrollment/renewal in the Board.

I am also aware that the decisions of the State Council of IMA Tamilnadu State Branch are final with regard to any matter concerned with the Private Hospital and Nursing Homes Board of IMA TamilNadu.

**HOSPITAL SEAL** **(SIGNATURE OF THE REPRESENTING DOCTOR)**

***To be filled in by the IMA Branch in which representing Doctor is a Life Member.**

The above statements(with special reference to item No ) made by the applicant have been verified to be true and is being recommended for enrolment in the Private Hospital and Nursing Home Board of IMA

**SEAL**

**Signature of the**
**President/Secretary/Dist. Coordinator**
**of the Branch Concerned**

**DETAILS REGARDING NAME/ ADDRESS/ PROPRIETORSHIP CHANGES FEE**

- Kindly Send this form duly filled through your IMA Branch Secretary office to the NHB, IMA TNSB.
- No Charges applicable for Name/ Address/ Proprietorship changes if sent during your Renewal, otherwise an amount of Rs.500/- applicable at all times.
- The Enrollment fee will have to be paid by Demand Draft drawn in favour of "IMA NHB GENERAL
- FUND" for Rs. 500/- payable at Hosur.

DD No.: _____Date:_____Bank _____Rs.500/- Place_____

This includes renewal of Hospital / Nursing Home in the Nursing Homes Directory and NHB Quarterly Journals. Special contribution can be raised at the time of need as decided by the State Council for any special activities.

**Send the filled-up application along with DD to:**

**DR.K. THIRUMAVALAVAN**
Hony. Secretary,
PH & NHB IMA TNSB
Sri Bharani Hospital,
No.05, Chairman Subbarayar Street, Villupuram – 605602
Phone: 04146-224775, CELL: 7548825544, 9443043452
E-mail ID: imanhbtnsb@gmail.com
Website: www.imanhb.org.in

**For Office Use:**

Received On: _____Receipt No. :_____

Enrollment No. : JM_____D.O.J :_____

Valid up to : _____

Certificate Sent on: _____By Post / Courier No. _____

Authorization Signature of IMA NHB_____