HEALTH CARES 4U

हमे ख्याल है आपका।

Corporate Office: Zila Parishad Building, 1st floor booth no 3 G T Road, bathinda

MEMBERSHIP RECEIPT FORM

Membership No.

Name:..

Father's Name:..

Date of Birth:..

PHOTO

Permanent Address:..

....

Mobile No. ☐☐☐☐☐☐☐☐☐☐ **Aadhar No.** ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

PHOTO	PHOTO	PHOTO
Name:........................	Name:........................	Name:........................
D.O.B:........................	D.O.B:........................	D.O.B:........................
Age:☐ Male:☐ Female:☐	Age:☐ Male:☐ Female:☐	Age:☐ Male:☐ Female:☐
Relation:.............. B,Group:..............	Relation:.............. B,Group:..............	Relation:.............. B,Group:..............
Aadhar No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐	Aadhar No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐	Aadhar No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

I/We fully understand that in case any information provided by me / us hearin is found to befake or incorrect than company has right to reject the membership.
I have willingly agree to pay the amount of rupees 999/- (Inc. all taxes) for membership card.

Executive Signature **Date:**........................ **Signature**

....

Membership Receipt

Membership No. **Date:**........................

Member Name:..

Executive Name:..

Received Ammount ₹ **Executive Signature**