



# HOSPITAL PROTECTION SCHEME OF PPLSSS OF IMA TAMILNADU



## MEMBERSHIP APPLICATION FORM

1. Name of Hospital (in Capital Letters) : \_\_\_\_\_
2. Date of Establishment : \_\_\_\_\_
3. Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Pin code: \_\_\_\_\_
- Telephone Nos. : \_\_\_\_\_ STD Code: \_\_\_\_\_
- E-mail : \_\_\_\_\_ Fax No : \_\_\_\_\_
4. IMA NHB No. : \_\_\_\_\_
5. Year of Enrolment : \_\_\_\_\_
6. Owner's / Managing Directors Name : \_\_\_\_\_
7. IMA Local Branch Name : \_\_\_\_\_
8. IMA Life Membership No : \_\_\_\_\_
9. IMA PPLSSS No. : \_\_\_\_\_
- Name of the Medical Council : \_\_\_\_\_
10. Category Applied : Primary Level / Secondary Level / Tertiary Level
11. Are you insured under indemnity Scheme : Yes / No  
If Yes, Name of the Insurance Company : \_\_\_\_\_  
Place: \_\_\_\_\_ Policy No: \_\_\_\_\_ Date of Expiry: \_\_\_\_\_

### FACILITIES AVAILABLE

12. Total No. of Beds : \_\_\_\_\_ General Wards : \_\_\_\_\_ Rooms : \_\_\_\_\_
13. ICU : Yes / No ICCU : Yes / No IMCU : Yes / No
14. O.T. : Yes / No if Yes No. of O.T : \_\_\_\_\_
15. Labour Room : Yes / No Laboratory : Yes / No X-Ray : Yes / No
16. Ultra Sound : Yes / No Physiotherapy : Yes / No

### STAFF PATTERN

17. No. of Consultants : \_\_\_\_\_
18. No. of Duty Doctors : \_\_\_\_\_
19. No. of Staff Nurses : \_\_\_\_\_ Qualified : \_\_\_\_\_ Trained : \_\_\_\_\_
20. No. of Technicians : \_\_\_\_\_ Qualified : \_\_\_\_\_ Trained : \_\_\_\_\_

21. Payment Details :

DD No. \_\_\_\_\_ Bank \_\_\_\_\_ Branch \_\_\_\_\_  
Amount \_\_\_\_\_ Date of Issue \_\_\_\_\_

Payment options DD

DD should be send in the name of "HPS of PPLSSS of IMA TN" Payable at **Omalur**

Send the filled up application along with payment information

**Dr. P. Manivannan, M.B.B.S, D.ORTHO.**, Hony.Secretary, PPLSSS of IMA TNSB.  
Sri Sugam Hospital (1st Floor), 149- E1,Bazaar Street, Omalur (PO), (TK), Salem - 636 455.  
Mob:9487272627, Ph:04290-290455

Despatch Details : Date \_\_\_\_\_ Courier/Registered Post/ in person

Date of commencement of membership will be from the date of receipt of DD at the principal office.

**DECLARATION**

I, \_\_\_\_\_ a Life Member of \_\_\_\_\_ Branch  
of IMA, do hereby, declare that the details furnished above are true and correct and that I will abide by  
the Rules and Regulations of Professional Protection Linked Social Security Scheme of IMA Tamilnadu as  
amended on 01.3.1998.

**I hereby authorize PPLSSS office to send Membership alerts via SMS and e-mail.**

Date:

Signature

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**Not For Renewal Members**

Forwarded: \_\_\_\_\_

Designation: \_\_\_\_\_

(To be forwarded by the local branch President/Secretary/PPLSSS District Co-ordinator)

Signature: \_\_\_\_\_

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**(FOR OFFICE USE ONLY)**

Date of Receipt :

Mode of Receipt : Courier/ Reg.Post /in person (Time: a.m/p.m)

Application Form : Complete/ Incomplete Remarks:

D.D. Realised on :

Date of Commencement of Membership :

Date of Despatch of Receipt to the Hospital/Nursing Home :

Date of Despatch of Certificate to the Hospital/Nursing Home :

HPS Membership No :

VRenewal Due on :

Letter of reminder sent on :

Renewal Fee received on :