AYUSH DOCTORS & PARA MEDICAL ASSOCIATION (ADPMA)

(**A Society Registered under the Society Registration Act, 1860**)

HEAD OFFICE: Aman Nagar, Behind Green Land School, Ludhiana–141008, Punjab (INDIA)

Contact: +91-98881-80388 | +91-93168-50388 | +91-92176-03232

Email: adpma2001@gmail.com | **Website:** www.adpma.in

MEMBERSHIP APPLICATION FORM

आवेदन पत्र – सदस्यता हेतु

Signature of the Applicant

NOTE: Please fill out this application form in CAPITAL LETTERS only

For New Membership | नई सदस्यता के लिए

APPLICATION DETAILS

Application No.: _____

Date: ____ / ____ / _____

Membership No. (Office Use):

_____

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1. MEMBERSHIP CATEGORY

सदस्यता श्रेणी

Please select ONE applicable category:

☐ **Basic Membership**

☐ **Professional Membership**

☐ **Lifetime Membership**

☐ **Institutional Membership**

If Other: _____

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2. APPLICANT'S PERSONAL DETAILS

आवेदक की व्यक्तिगत जानकारी

Full Name (as per Aadhaar / Official Document):

Father's / Husband's / Mother's Name:

Date of Birth: ____ / ____ / _____

Gender:

☐ Male ☐ Female ☐ Other

Marital Status:

☐ Married ☐ Unmarried ☐ Other

Aadhaar / Government ID – Last 4 Digits: _____

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3. CONTACT DETAILS

संपर्क विवरण

Mobile No.: _____

Alternate Mobile No.: _____

Email ID: _____

Correspondence Address:

Village / Town / City: _____

District: _____

State: _____

PIN Code: _____

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4. EDUCATIONAL QUALIFICATION

शैक्षणिक योग्यता

A. SECONDARY / 10th STANDARD

Board: _____

Year of Passing: _____

Roll / Certificate No.: _____

Percentage / Grade: _____

B. SENIOR SECONDARY / 12th STANDARD

Board: _____

Year of Passing: _____

Stream:

☐ Science ☐ Arts ☐ Commerce ☐ Other: _____

Roll / Certificate No.: _____

Percentage / Grade: _____

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5. PROFESSIONAL / MEDICAL QUALIFICATION

व्यावसायिक / चिकित्सा योग्यता

Highest Professional Qualification:

Course / Degree / Diploma:

Specialization / System:

☐ Ayurveda
☐ Homoeopathy
☐ Unani
☐ Naturopathy & Yoga
☐ Siddha
☐ Para-Medical / Allied Health
☐ Other: _____

Name of Institution / University / Board:

_____

Year of Passing: _____

Duration of Course: _____

_____

6. MEDICAL / PROFESSIONAL REGISTRATION

मेडिकल / प्रोफेशनल रजिस्ट्रेशन

Do you hold any Medical / Professional Registration?

☐ Yes ☐ No ☐ Not Applicable

Registration Number: _____

Registration / Licensing Authority / Council:

_____

State: _____

Date of Registration: ____ / ____ / _____

Valid Upto, if applicable: ____ / ____ / _____

Registration Status:

☐ Active ☐ Other: _____

Medical / Professional Registration Certificate Attached:

☐ Yes ☐ No ☐ Not Applicable

Note: Where applicable, professional registration must be issued by the competent statutory / regulatory authority. ADPMA membership does not substitute for such registration.

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7. PROFESSIONAL EXPERIENCE

व्यावसायिक अनुभव

Do you have professional / work experience?

☐ Yes ☐ No

Name of Organization / Hospital / Clinic / Institute:

Designation: _____

Nature of Work / Department:

_____

From: ____ / ____ / _____ **To:** ____ / ____ / _____

Total Experience: _____

Experience Letter Attached:

☐ Yes ☐ No

If more than one organization, attach an additional sheet.

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8. CURRENT PROFESSIONAL DETAILS

वर्तमान व्यावसायिक विवरण

Present Occupation / Designation:

Current Organization / Clinic / Hospital / Institute:

Work Address:

City: _____ **State:** _____

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9. MEMBERSHIP PURPOSE

सदस्यता लेने का उद्देश्य

Please indicate the primary purpose of joining ADPMA:

☐ Professional Association & Networking

☐ Professional Development

☐ Participation in Seminars / Workshops / Conferences

☐ Professional Community Activities

☐ Institutional / Organizational Association

☐ Other: _____

Briefly state your purpose of joining ADPMA:

_____

_____

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10. DOCUMENT CHECKLIST

आवश्यक दस्तावेजों की सूची

Please tick ✓ against the documents submitted with the application.

Sr. No.	Required Document	Submitted
1	**10th Certificate / Marksheet**	☐

Sr. No.	Required Document	Submitted
2	**12th Certificate / Marksheet**	☐
3	**Professional / Medical Qualification Certificate**	☐
4	**Medical / Professional Registration Certificate – if applicable**	☐
5	**Experience Letter – if applicable**	☐
6	**Aadhaar Card / Government-issued Identity Proof**	☐
7	**Recent Passport-size Photograph – 1 Photo Pasted on Form**	☐
8	**Recent Passport-size Photographs – 2 Photos Attached Separately**	☐
9	**Other Supporting Document, if required**	☐

PHOTOGRAPH REQUIREMENT

Photo 1: One recent passport-size photograph must be **pasted in the photograph box provided on the first page**.

Photo 2 & Photo 3: Two recent passport-size photographs must be **attached separately** with the application form.

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11. DOCUMENT VERIFICATION

दस्तावेज सत्यापन

For ADPMA Office Use Only

Documents Received:

☐ Complete ☐ Incomplete ☐ Additional Documents Required

Originals Seen / Verified:

☐ Yes ☐ No ☐ Not Required

Qualification Verified:

☐ Yes ☐ No

Professional Registration Verified:

☐ Yes ☐ No ☐ N/A

Experience Verified:

☐ Yes ☐ No ☐ N/A

Identity Proof Verified:

☐ Yes ☐ No

Verified By: _____

Designation: _____

Date: ____ / ____ / _____

Remarks:

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12. APPLICANT'S DECLARATION

आवेदक की घोषणा

I hereby apply for membership of the **AYUSH Doctors & Para Medical Association (ADPMA)**.

I declare that all information furnished by me in this application and in the documents submitted with it is true, correct and complete to the best of my knowledge and belief. I understand that ADPMA may verify the information and documents submitted by me and may request additional documents or clarification whenever considered necessary.

I undertake to inform ADPMA of any material change in my qualification, professional registration, employment/professional status, contact details or other information relevant to my membership.

I agree to abide by the applicable **Constitution, Bye-Laws, Rules, Regulations, Membership Terms & Conditions and Code of Conduct of ADPMA**, as amended from time to time.

I understand and acknowledge that **membership of ADPMA is an association membership only**. It does not by itself constitute or confer any government recognition, statutory registration, professional licence, medical practice licence, qualification recognition, or independent right to practice any system of medicine or healthcare profession.

I further undertake that I shall not use the name, membership, certificate, ID card, logo or other association documents of ADPMA in any manner that may falsely imply government authorization, statutory registration, professional licensing, or recognition by any competent authority.

I understand that submission of this application does not automatically guarantee membership. Membership shall become effective only after verification, approval by the competent authority of ADPMA and completion of applicable formalities and payment of prescribed membership fees.

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13. UNDERTAKING

I confirm that:

☐ The information provided in this form is true and accurate.

☐ The documents submitted are genuine and belong to me.

☐ I have not knowingly concealed any material information relevant to this application.

☐ I will comply with the applicable rules and Code of Conduct of ADPMA.

☐ I will not represent ADPMA membership as a statutory licence, government approval or professional registration.

☐ I will comply with all applicable laws, rules, regulations and requirements of the competent authority governing my qualification and professional activities.

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14. APPLICANT'S SIGNATURE

Applicant's Signature: _____

Applicant's Full Name: _____

Place: _____

Date: ____ / ____ / _____

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15. FOR ADPMA OFFICE USE ONLY

Application Status:

☐ Approved
☐ Approved – Subject to Additional Documents
☐ Pending
☐ Rejected

Approved Membership Category: _____

Membership No.: ADPMA//

Membership Valid From: ____ / ____ / _____

Membership Valid Upto: ____ / ____ / _____

Membership Fee Received: ₹ _____

Receipt No.: _____

Payment Mode: _____

ID Card No.: _____

Certificate No.: _____

QR / Online Verification:
☐ Created ☐ Updated ☐ N/A

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16. FINAL APPROVAL

Recommended / Verified By

Name: _____

Designation: _____

Signature: _____

Date: ____ / ____ / _____

APPROVED BY – AUTHORIZED SIGNATORY

Name: _____

Designation: _____

Signature: _____

Date: ____ / ____ / _____

OFFICIAL SEAL

IMPORTANT NOTICE

ADPMA membership is an association membership and should not be represented as a statutory licence, government recognition, medical practice authorization, professional registration or qualification recognition. Members remain responsible for maintaining any qualification, registration, licence, permission or authorization required by the applicable competent authority for their professional activities.

Incomplete applications may be kept pending until the required information/documents are provided. ADPMA reserves the right to verify submitted information and documents and to accept, defer or decline an application in accordance with its applicable Constitution, Bye-Laws, Rules and Membership Policy.

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