FORM-5

Application for seeking permission to practice in other State

{ Sub-Regulation (i)(2) of regulation 8 of F.No.2-11/20211-BERH/NCH/11055 }

To,

The Registrar,
Council of Homoeopathic System of Medicine,
Gujarat State,
Ahmedabad.

Sub:- For Enrollment to practice in Gujarat State-Reg.

Madam/Sir,

I am in possession of_____qualification and having valid Reg. No_____ issued by _____State Medical Council for Homoeopathy / Registering Authority on_____ _____.

Degree issues by University_____ _____.

I desire to practice at _____ _____ (Address) for a period of _____w.e.f._____. Kindly add my name in your Adjunct Register and issue me enrollment letter. My Registration is updated till date. I am ready to pay required fees. Self-attested copies of following documents are enclosed namely:-

(i) All Marksheet;
(ii) Degree / Diploma;
(iii) Internship Certificate;
(iv) Internship Complition Certificate;
(v) Registration Certificate with proof of update;
(vi) New address proof;
(vii) School/College leaving Certificate;
(viii) NRH Reg. Copy;

It is certified that no ethical proceedings of any type are pending against me with any authority / State.

Thanking you.

Your Sincerely,

Dated: _____

( )

Residence. Address:- _____
_____

Email:- _____

Mob:- _____

Office use only.

-> Sr.No._____

-> State Enrollment number._____

National Commission for Homoeopathy

FORM-6

[Regulation 8(2) (i)]

Passport Size Photo

(1) Name of professional (IN BLOCK LETTERS):_____

(2) Father's name (IN BLOCK LETTERS):_____

(3) New address of practice or work:_____

_____

(4) Permanent address:_____

_____

(5) Aadhaar number:_____

(6) Phone Fax and mobile numbers:_____

(7) E-mail address:_____

(8) Date of Birth:_____

(9) Nationality:_____

(10) Name of medical degree or diploma:_____

(i) University: _____

(ii) Month & year of passing:_____

(11) Registration particulars:-

(i) Registration number:_____

(ii) Date of registration: _____

(iii) Name(s) of the register(National / State):_____

(iv) Whether the registration is renewable or permanent:_____

(12) Name of hospital or institute with complete address for purposes of teaching or research or practice of medicine: _____

_____

(13) Name of person in institution or hospital who will be responsible for legal issues regarding patient care provided by doctor concerned: _____

_____

Date: -_____ Sign,

Place: -_____ ( )