**Institutional Membership – Year (\_\_\_\_)**

Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domain of Healthcare Expertise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of years in the healthcare industry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Geographical Presence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Representative / Nominee Details:**

Title: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender (M/F): \_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position in Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Degree Earned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Membership Type** | **Mark Box ‘X’** | **One-time Enrolment Consideration** | **Annual Renewal Fee** |
| **Stand Alone Hospitals/****Nursing Homes/****Polyclinics** |  | **INR 3000** | **INR 5000** |
| **Hospital Chains /****Pharmacy Chains /****Diagnostic Chains /****Wellness Centres** |  | **INR 3000** | **INR 12000** |
| **Insurance Companies** |  | **INR 3000** | **INR 12000** |
| **Third Party****Administrators** |  | **INR 3000** | **INR 5000** |
| **Pharmaceutical****Companies** |  | **INR 3000** | **INR 22000** |
| **IT / ITES/Medical****Technology Companies** |  | **INR 3000** | **INR 22000** |
| **NGOs/ Industry****Associations** |  | **INR 3000** | **INR 7000** |

|  |
| --- |
| **Method of Payment** |
| **Demand Drafts** - Demand Draft to be drawn in favour of ‘**Disease Management Association of India**’ |
| **Mailing Address** |
| Disease Management Association of India102, Siddhivinayak, Plot no,3, Sector 14, Khanda Colony, New Panvel, Mumbai 410206, Maharashtra, India.  |Tel: +91 8123618929 |F: +91 11 4582 33 55 | W: www.dmai.org.in |

**Applicant Signature**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Terms and Conditions**

* Membership is open to all stakeholders in the Population Health Improvement community
* Membership of DMAI is valid for one year – Calendar year ( Jan- Dec)
* Membership fee is not transferable , refundable or prorated
* The membership is confirmed upon receipt of a duly filled in form with proper fees being paid
* If you are a Government run organization , you are entitled to a complimentary membership. Please fill the form and send it with an undertaking from the Head of the Institute / organization . However, your members / students shall have to pay the fees as stipulated in the form when applying for membership