FORM FOR RADIOLOGIST/DIAGNOISTIC/PHYSIOTHERAPY CENTER

1.	Name of the Doctor		
2.	Name of the Diagnostic Center, if any		
3.	Educational/Professional Degree		
4.	Date of birth & Age	(dd/mm/yy)	Age : ____ Years
5.	Locational Address		Paste your Passport size Photograph here
	Address for correspondence (*if different than residence address)*		
6.	Cell No(s). Email ID	(1) ____________________ (2) ____________________ ______________________________________	
7	Regn. No. (under PC-PNDT Act) Regn. No. (under Shops & Estt. Act) Other Regn No.		
8.	Operational since when	Years	
9.	Whether on Ground floor?		

<u>Details of equipments/facilities available:</u> (Please provide as much of details as you may together with photographs of the equipments etc.

....

दिनांक सह हस्थाक्षर मुहर के साथ / Signature with dated & Seal