H.P. Cal.-

ESIC-MED-78

MEDICAL ACCEPTANCE CARD

Full Name: _____

Father or Husband's Name : _____

Factory Name : _____

Present Residential Address : _____

_____

HS No._____

Ref No._____

EMPLOYEES' STATE INSURANCE CORPORATION

I apply to be included in the list of Dr. _____

I declare that I am not already in the list of a doctor in this or any other area.

Date:_____ Signature or Thumb impression of Insured Person

To be completed by Doctor

Doctor Code No: _____

I accept this person for inclusion of my list

Date: _____ Signature of Doctor