H.P. Cal.- ESIC-MED-78

MEDICAL ACCEPTANCE CARD

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| --- |
| Full NameFather or Husband's Name Factory NamePresent Residential address |
|  |  |
| Ins. No./ Ref. No. |  |

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| **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 bv Doctor: | Doctor's Code No. |  |
| I accept this person for inclusion in my listDate: Signature of the Doctor. |