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

MEDICAL ACCEPTANCE CARD

|  |  |
| --- | --- |
| Full Name  Father or Husband's Name Factory Name  Present 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 list  Date: Signature of the Doctor. | | |