 **DOWELS**

**FOR OFFICE USE ONLY**

Application No- ………………….

Membership No- ………………….

Enrolment Date- ………………….

**DOCTORS’ WELFARE ASSOCIATION**

**(GUARANTEE) LIMITED**

DOCTORS’ NETWORK FOR CHARITY & WELFARE

PASSPORT SIZE PHOTO

**APPLICATION FORM**

1. **Personal Details**
2. Surname with initials ………………………………………………………………………………..…………

(In Block Capitals)

1. Names Other than surname ………………………………………………………………………………………………

(In Block Capitals)

……………………………………………………………………………………………………….............

1. Gender Male…………. Female………………

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |

1. NIC

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |

1. SLMC

1. Graduated University …………………………………………………………………………………………………………………..
2. Permanent Address …………………………………………………………………………………………….…………………….

…………………………………………………………………………………………....………..…………..

………………………………………………………………………………………………..…..…………….

1. Postal Address ………………………………………………………………………………………..….……………

……………………………………………………………………………………..……….…………

……………………………………………………………………………………………….…….…

1. Marital States. Married………… Unmarried………….. Divorced…………….
2. Date of Birth ………/…………/……………………
3. Present working Station
4. Hospital/Department …………………………………………………………………..………….
5. Unit …………………………………………………… Consultant ……………………….…………..
6. Designation ………………………………………………………………
7. Contact details

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |

1. Mobile

Add to Dowels Viber Group – Yes (…..) No (…..)

1. Fixed line ……………………………………………/……………………………………………...
2. E mail …………………………………………………………..…………….
3. Preferred payment method Monthly…………….. Annually………………………
4. Preferred bank ( select one of them)

|  |  |  |
| --- | --- | --- |
| **Bank** |  | **Account Number** |
| BOC |  |  |
| COMMERCIAL |  |  |
| BY HAND |  |  |

1. Name of the EXCO member who introduced you to the association

|  |  |  |
| --- | --- | --- |
| **Name** | **Unit** | **Contact Number** |
|  |  |  |
|  |  |  |

1. I hereby nominate the person/ persons mentioned below and confer on him/her/ them the right to receive any gratuity in the event of my death.

1. ……………………………………………………………………………………

2. …………………………………………………………………………………..

I here by confirmed that above mentioned factors are true and I would agree to follow all the rules and regulation of Doctors’ Welfare Association. (DOWELS)

………………………………………………. ……………………………………………

Signature Date

**OFFICE USE ONLY**

**Director Board Approval**

Proposed By : ……………………………………………………………

Seconded By : 1. ……………………………………………………………

2. ……………………………………………………………

…………………………………………………………….

Chairman : Director Board

1. **Family Details**
2. **Spouse**

* Full Name- ………………………………………………………………………………………………………….

…………………………………………………………………………………………………………..

* Age- ………………………………………………..
* Occupation- ………………………………………………..
* NIC No- ……………………………………………….
* Telephone No- ……………………………………………….

1. **Children**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Name | Date of Birth | Status | | | |
| Schooling | Higher Education | Occupied | Married |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |

1. **Details of other Family Members**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  | Name | Age | Occupation |
| (A) | Parents of Member | 1 |  |  |  |
|  | 2 |  |  |  |
|  |  |  |  |  |  |
| (B) | In-laws | 1 |  |  |  |
|  | 2 |  |  |  |
|  |  |  |  |  |  |
| (C) | Siblings of the member | 1 |  |  |  |
|  | 2 |  |  |  |
|  | 3 |  |  |  |
|  | 4 |  |  |  |
|  | 5 |  |  |  |

**Please submit copies of,**

* **Marriage certificate**
* **Birth certificates of Member, Spouse, Children with the application**

I hereby confirmed that above mentioned facts are true and I would agree to follow all the rules and regulations of the Doctors’ Welfare Association. (DOWELS)

………………………………………………… ………………………………………………….

Signature Date