H.P. Cal.-6/92/1,00,000 **ESIC-MED-7B**

MEDICAL ACCEPTANCE CARD

Full Name .....

Father or Husband's Name .....

Factory Name .....

Present Residential address

Ins. 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's Code No.**	

I accept this person for inclusion in my list

Date: **Signature of the Doctor.**