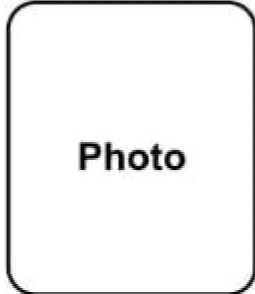
CARE U WELL

HEALTH SERVICES PRIVATE LIMITED

Corporate Office : 277-D/B, Amrit Palace, Nipania, Indore, (M.P.) 452007

Membership No.

MEMBERSHIP RECEIPT FORM



Name :..

Father's Name :..

Date of Birth : ....

Permanent Address : ....

....

Mobile No. ☐☐☐☐☐☐☐☐☐☐ Aadhar No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

1 Member Photo	1 Member Photo	1 Member Photo
Name	Name	Name ....
D.O.B.	D.O.B.	D.O.B. ....
Age. ☐ Male ☐ Fenale ☐	Age. ☐ Male ☐ Fenale ☐	Age. ☐ Male ☐ Fenale ☐
Relation .... B,Group.........	Relation .... B,Group.........	Relation .... B,Group.........
Aadhar No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐	Aadhar No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐	Aadhar No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

I/we fully understand that in case any information provided by me / us hearin is found to be fake or incorrect than company has right to reject the membership.
I have willingly agree to pay the amount of rupees 250/- (Inc. all taxes) for membership card.

Executive Signature   Date ....   Signature

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Membership Receipt

Membership No.   Date ....

Member Name : ....

Executive Name : ....

Received Amount ₹ ☐

Executive Signature