PROVIDER ACCREDITATION FORM

Requestor Details

Requested By:	______________________	**Date of Request:**	______________________
Mobile No.:	______________________	**Email Address:**	______________________

Provider Details (hospitals / clinics / dental clinics)

Name of Provider:	______________________	**Address:**	______________________
Contact Person:	______________________	**Designation/Position:**	______________________
Landline No.:	______________________	**Email Address:**	______________________
Mobile No.:	______________________		

Doctor's Details

Name of Doctor:	______________________	**Specialization:**	______________________
Hospital/Clinic Affiliation:	______________________	**Hospital/Clinic Affiliation:**	______________________
Room No.:	______________________	**Room No.:**	______________________
Secretary:	______________________	**Secretary:**	______________________
Landline No.:	______________________	**Email Address:**	______________________
Mobile No.:	______________________		