INSTITUTE OF HEALTHCARE MANAGEMENT, NIGERIA

MEMBERSHIP FORM

APPLICATION No:_____

PERSONAL INFORMATION:

Full Name:_____

First Name Middle Name Last Name

Sex: _____**Date (dd/mm/yyyy):** _____**Place of birth:** _____

Current mailing address: _____

_____

_____

Tel: _____ **Mobile:** _____ **Email:** _____

Permanent home mailing address: _____

_____

_____

EDUCATIONAL QUALIFICATION:

QUALIFICATION	NAME AND LOCATION OF INSTITUTION ATTENDED	YEAR OF ENROLLMENT	MAJOR/ SPECIALISATION	YEAR OF GRADUATION

Note: Attach photocopy of aforementioned credentials

Particular of scholarship, Prizes, Awards, etc. Awarded (please use additional sheet if necessary)

MEMBERSHIP OF PROFESSIONAL BODIES (attach photocopy of certificates)

NAME OF PROFESSIONAL BODIES	GRADE OF MEMBERSHIP	DATE OF ELECTION

EMPLOYMENT RECORD:

ORGANISATION	NATURE OF RESPONSIBILITY	DURATION FROM/TO	RECOGNISION/AWARD	DESIGNATION

I hereby certify that information provided by me is true to the best of my knowledge

_____ _____

Signature of the applicant Date

SPONSOR: (must be an associate,full member or fellow of the institute)

Full Name: _____

Membership Grade: _____

Membership number: _____

Organisation: _____

_____ _____

Signature of sponsor Date