



# Community Development Medicinal Unit West Bengal

**Head Office:** 86C Dr. Suresh Sarkar Road, Kolkata 700 014, India.

**Siliguri Office:** East Vivekananda Pally, Raja Rammohan Roy Road,  
P.O. Rabindra Sarani, Siliguri 743 006, India.

**CDMU Documentation Centre:** 47/1B Garcha Road, Kolkata 700 019, India.

## Partner membership application form

This membership is a formal requirement of Community Development Medicinal Unit [CDMU] West Bengal before it can provide service to any not-for-profit organizations, who are registered with the Register of Societies or have other legal status. The membership is available on submission of this application form along with the nominal lifetime Registration Fee of Indian Rs. 100/- [rupees hundred only], subject to acceptance of the application form by CDMU Executive Committee. You are requested to fill up this form and submit it along with the membership fee Rs. 100/- [rupees hundred] only by Cash / Cash / Demand Draft / Money Order in favor of 'Community Development Medicinal Unit'. A copy of your Society Registration Certificate, latest annual report, balance sheet and a valid memorandum of association are also required.

**Please fill-in the print version of this form and mail it with necessary documents to:  
Secretary, Community Development Medicinal Unit, 86C Dr. Suresh Sarkar Road, Kolkata 700 014.  
If the online version is submitted, membership will not be confirmed till the duly filled-in print version with supporting documents reach us.**

*[To be filled in by the applicant – Please attach separate sheet if necessary]*

We are interested to become partner member of CDMU. We give below details of our organization.

1. Name of the organization: \_\_\_\_\_

2. Registration number and year: \_\_\_\_\_

3. Full postal address: \_\_\_\_\_  
\_\_\_\_\_

4. Telephone no(s): \_\_\_\_\_ Fax no(s): \_\_\_\_\_

5. E-mail: \_\_\_\_\_ Website: \_\_\_\_\_

6. Name of the chief functionary of the organization: \_\_\_\_\_

7. Name and designation of contact person in relation to medical supplies from CDMU:  
\_\_\_\_\_

8. Details of location to enable CDMU's delivery team to reach easily (if relevant):  
\_\_\_\_\_

Continued



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9. Areas of activity (please indicate which activities are major): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

10. Type of healthcare provided: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

11. Average out-patient attendance per day (if applicable): \_\_\_\_\_

12. Average indoor admission per month (if applicable): \_\_\_\_\_

13. Future plan in area of healthcare: \_\_\_\_\_

\_\_\_\_\_

I hereby declare that the information furnished in this application form is true to my knowledge and I / we agree to fulfill the applicable terms & conditions to become CDMU's partner member.

Full name of the applicant \_\_\_\_\_

Official seal

Designation: \_\_\_\_\_

Signature with Date: \_\_\_\_\_

**For CDMU office use only**

Membership recommended by: \_\_\_\_\_ Accepted by: \_\_\_\_\_

Application receipt date: \_\_\_\_\_ Application filed by: \_\_\_\_\_

Signature with date