Medical Camp Registration Form

Bidada International Foundation
11403 Tortuga St
Cypress, CA 90630 USA

In consideration for Bidada International Foundation (the "Foundation") admitting me as a volunteer for the Medical Camp (the "Program"), which may involve travel to, from, and within the country India.

I hereby:

(a) release and discharge the Foundation from any liability or responsibility for any injury (including death), and for any damage to or loss of property, howsoever caused, that I suffer as a result of or in connection with my participation in the Program or any travel related to the Program, including, without limitation, any injury, loss, or damage resulting from, arising out of, or occurring in connection with the negligent acts or omissions of members of the Foundation or other employees or agents of the Foundation; and

(b) agree not to raise any claim or to institute any legal action or proceeding against the Foundation for any cause of action that may result from or arise out of or in connection with my participation in the Program or any travel related to the Program, including without being limited to, any cause of action that may result from or arise out of or in connection with the negligent acts or omissions of members of the Foundation or other employees or agents of the Foundation.

All references to the Foundation in this form shall include, and all provisions of this form shall inure to the benefit of, the Foundation members, officers, employees, agents, servants and representatives.

I will inform an appropriate representative of the Foundation named above of any special information regarding my health, physical or mental condition, that may be relevant to my participation in the Program or any travel related to the program.

Name:_____________________________________ Date:________________

Date of Birth:_______________

By checking this box I agree to the terms and conditions stated above.

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Medical Camp Registration Form

Name:____ Gender: M F Age:__________

Address:____ City:____________________

State/Province:________________ Zip/Postal:_____________ Country:____________________

Phone:____________________________ Secondary Phone:______________________________

Email:____

Address in India:_______________________________________ City:____________________

State/Province:________________ Zip/Postal:_____________ Phone:____________________

Participant Status:

General Volunteer Physician Resident, Year:_______ Med Student, Year:_______

If Physician/Resident/Medical Student/Nurse:

Medical Degree:____________________________

Institution:____________________________

Year Issued:____________________________

Professional Affiliation:________________________

If Volunteer:

Education:____________________________

Area of Interest:____________________________

List two persons in India or abroad that we may contact in the case of an emergency:

1. Name:______________________________________ Relationship:____________________

Address:____ City:____________________

State/Province:________________ Zip/Postal:_____________ Country:____________________

Phone:____________________________ Email:____

2. Name:______________________________________ Relationship:____________________

Address:____ City:____________________

State/Province:________________ Zip/Postal:_____________ Country:____________________

Phone:____________________________ Email:____

List any medical conditions we should be aware of, medications used to treat those conditions, and any medications that may induce an allergic reaction:

____

____

Additional Information:

____

Date:____________________

By checking this box I certify that the above information is true and correct.

Medical Camp Registration Form
Shree Bidada Sarvodaya Trust
Village : Bidada, Taluka : Mandvi, Kutch, Gujarat, INDIA - 370 435
FCRA 1976 No. 042050010

Foreign visitor information required by the government of India

1	**Serial Number**	☐ None
2	**Name and Permanant Address &Contact Number**	
3	**Name and Permanant Address &Contact Number in India**	
4	**Nationality**	☐ USA ☐ Canada ☐ Other:____________
5	**Purpose of visit**	☐ Medical Camp ☐ Friends & Family ☐ Other:____________
6	**Amount of Donation in Indian Rs. (If Any)**	☐ None ☐ Other:____________
7	**Details of Last visit (If Any)**	
8	**Duration of this visit From(Date) - To (Date)**	-
9	**Details of the Place of stay in India (specially night stay)**	☐ Medical Camp ☐ Alt Address:____________________________
10	**Link between foreigner and NGO / Trustees**	☐ None ☐ Other:____________
11	**Mode of Conveyance adopted by the foreigner (Train/Air)**	☐ Train ☐ Air ☐ Car
12	**Visiting from, Arriving to (Specify City, State, Country)**	
13	**Passport Number with date of Issue**	
14	**VISA Number**	
15	**Type of VISA (Business, Tourist etc.)**	
16	**Validity of VISA (From - To)**	

All information must be filled out by in order to process registration.

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In order to attend the medical camp, travel and lodging arrangements from Mumbai to Bidada and back to Mumbai must be made well in advance. To avoid any last minute difficulties the Foundation makes all the necessary reservations and arrangements for its attendees. Please take note of the available travel options with pricing listed below and select the one that best fits your needs. Prices are listed by form of transportation and duration of stay; a donation to the Foundation is suggested but not required.

Travel Options

	1 Week Stay	2 Week Stay	3 Week Stay	
Train	$100	$150	$200	
Air	$300	$350	$400	
Donation (Optional)	$50	$100	Other:______	

Total:__________

Payment for these accommodations can be submitted to the Foundation online via PayPal, or by mailing a check to the address below. Funds collected are not refundable but are tax deductible.

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Cypress, CA 90630 USA

To ensure that the necessary arrangements are taken care of in time the Foundation must receive this form as well as payment for the totaled amount as soon as possible. Participants who do not submit payment by this date will not be assisted with travel accommodations between Bidada and Mumbai.

For Physician Use Only

Form MCI-07

MEDICAL COUNCIL OF INDIA

Pocket - 14, Sector - 8, Phase-I, Dwarka, New Delhi - 110 077
Phone : 011-25367033,25367035, 25367036,
Email : mci@bol.net.in, Website : http://www.mciindia.org

APPLICATION FORM FOR GRANT OF TEMPORARY PERMISSION U/S 14(1) TO FOREIGN NATIONAL HOLDING NON-SCHEDULE MEDICAL QUALIFICATION FOR TEACHING, RESEARCH OR CHARITABLE WORK AND TEMPORARY REGISTRATION FOR POSTGRADUATE TRAINING (TRAINING PROGRAMS, STUDY PROGRAMS, MODULES AND SHORT TERM COURSE)

(Please read the instructions carefully given in Appendix-I before filling the form.)

Application for Temporary Permission/ Registration:

Training ☐ **Teaching/ Research or Charitable work** ☐

1. NAME OF THE APPLICANT
(IN BLOCK LETTERS)

2. FATHER'S NAME
(IN BLOCK LETTERS)

3. A) DATE AND PLACE OF BIRTH

   B) NATIONALITY

4. NAME OF THE MEDICAL DEGREE/DIPLOMA OBTAINED AND UNIVERSITY/LICENSING BODY WITH THE MONTH AND YEAR OF PASSING THE QUALIFICATION.

5. WHETHER PREVIOUSLY VISITED IN INDIA IF SO DATE, PERIOD AND PLACE OF PREVIOUS VISIT.

6. REGISTRATION PARTICULARS:
(a) ARE YOU REGISTERED IN ANY FOREIGN COUNTRY? IF SO, GIVE NAME OF THE BODY WITH WHICH REGISTERED AND THE NUMER AND DATE OF REGISTRATION.

   (b) ARE YOU REGISTERED AS A PRACTITIONER IN YOUR OWN COUNTRY? IF SO GIVE THE NAME OF THE BODY WITH WHICH REGISTERED AND THE NUMBER AND DATE OF REGISTRATION.

(c) WHETHER THE REGISTRATION IS RENEWABLE
OR PERMANENT.

(d) ARE YOU HAVING CURRENT REGISTRATION IN
YOUR OWN COUNTRY, IF SO, STATE THE NO. &
DATE OF REGISTRATION WITH THE NAME OF
OF THE STATE MEDICAL COUNCIL.

7. NAME OF THE MEDICAL COLLEGE
/INSTITUTION WHERE THE CANDIDATE
IS ALLOWED FOR ADMISSION TO
POSTGRADUATE TRAINING/STUDIES.
DATE AND FACULTY

8. NAME OF THE SPONSORING AUTHORITIES
WITH COMPLETE ADDRESS (AUTHORISATION
DOCUMENT TO BE ENCLOSED)

9. NATURE OF EMPLOYMENT IN MEDICAL
COLLEGE/ HOSPITAL OR MEDICAL INSTITUTION
IN INDIA GIVING DATES OR ANY SPECIFIC
PURPOSE APPROVED BY GOVERNMENT OF INDIA.

10. IS THE EMPLOYMENT TEMPORARY OR PERMANENT
OR FOR A NUMBER OF YEARS

11. PRESENT ADDRESS
(BLOCK CAPITAL LETTERS).

12. <u>DETAILS OF PAYMENT OF FEES</u>:

(a) PAID BY CASH/DEMAND DRAFT :

(b) AMOUNT RUPEES :

!3. <u>DETAILS OF DEMAND DRAFT</u>:-

(a) NAME & ADDRESS OF ISSUING BANK

(b) DEMAND DRAFT NO. _________________DATED____________

(c) IF AMOUNT IS PAID BY CASH THEN CASH RECEIPT NO.
AND DATE AS ISSUED BY THE ACCOUNT SECTION OF MCI

SIGNATURE OF THE APPLICANT

DATE: _____________

PLACE: _____________

APPENDIX-I
INSTRUCTIONS

1. THE APPLICATION FORM SHOULD BE PROPERLY AND NEATLY FILLED IN AND SHOULD BE SUBMITTED ALONG WITH THE FOLLOWING DOCUMENTS: -

   a) PROVISIONAL DEGREE OR DIPLOMA OR CERTIFICATE OF HAVING PASSED THE MEDICAL EXAMINATION ISSUED BY THE DEAN OF THE COLLEGE /UNIVERSITY

   b) IF THE DIPLOMA OR CERTIFICATES ARE IN ANY OTHER REGIONAL LANGUAGES A TRUE COPY OF THE SAME AS WELL AS AUTHENTIC ENGLISH TRANSLATION.

   c) FIVE SETS OF :-

      (I) COPY OF CERTIFICATE OF CURRENT REGISTRATION IN YOUR OWN COUNTRY DULY ATTESTED.
      (II) CERTIFICATE FROM THE HEAD OF THE INSTITUTION UNDER WHICH THE CANDIDATE IS EMPLOYED / TO BE EMPLOYED TO THE EFFECT THAT SERVICES RENDERED BY THE FOREIGNER ARE FOR THE PURPOSE OF TEACHING, RESEARCH OR CHARITABLE WORK AND NOT FOR PERSONAL GAIN.

   d) NON REFUNDABLE APPLICATION FEE OF RS. 5000/- (RUPEES FIVE THOUSAND ONLY) BY A BANK DRAFT IN FAVOUR OF "THE SECRETARY, MEDICAL COUNCIL OF INDIA", PAYABLE AT NEW DELHI. ON REVERSE OF THE DRAFT, FOLLOWING DETAILS TO BE FILLED BY THE APPLICANT AND DULY SIGNED: -

      (i) Name
      (ii) Father's Name
      (iii) Purpose for which the draft submitted
      (iv) Telephone No with Code/Mobile No.

   e) IN CASE OF PAYMENT IS MADE IN CASH, IT WILL BE MADE ONLY TO AUTHORIZED OFFICER IN ACCOUNT SECTION OF MCI AND RECEIPT OBTAINED IN DUPLICATE. ORIGINAL COPY OF RECEIPT WILL BE ATTACHED WITH THE APPLICATION AND DETAILS OF SUCH PAYMENT FILLED BY THE APPLICANT IN THE FORM. DUPLICATE COPY OF RECEIPT WILL BE RETAINED BY THE APPLICANT. NO PAYMENT WILL BE MADE IN CASH TO ANY PERSON OF MCI AT THE COUNTER OR ANY WHERE ELSE EXCEPT IN ACCOUNT SECTION.

2. APPLICANT IS ADVISED TO RETAIN COPY OF HIS APPLICATION AND DRAFT FOR FUTURE REFERENCE

3. PLEASE NOTE THAT THE APPLICATION MUST RECEIVE BY THE COUNCIL **AT LEAST TWO MONTHS** BEFORE THE SCHEDULE DATE OF PRACTISING MEDICINE IN INDIA.

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Form MCI-07

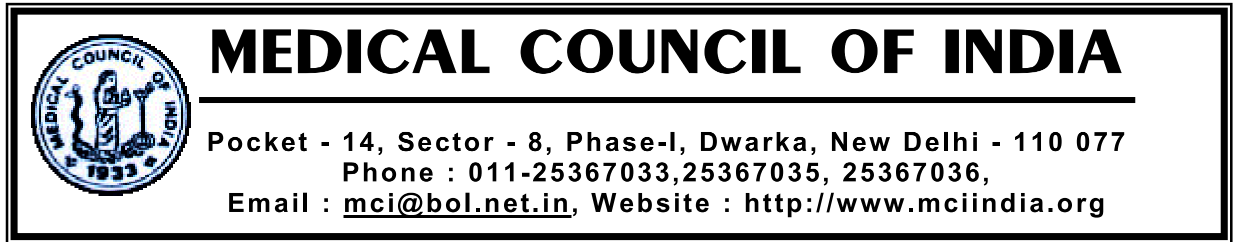
CHECK LIST for submission of documents

THE CANDIDATES ARE REQUESTED TO ENSURE THAT THE DOCUMENTS BE ENCLOSED AS PER THE ORDER IN THE CHECKLIST. ALL PAPERS/DOCUMENTS SHOULD BE NUMBERED ACCORDING TO THE CHECKLIST. PLEASE ARRANGE THE APPLICATION IN THE FOLLOWING ORDER & TICK MARK THE RELEVANT BOXES:

1. Bank Draft: [Yes] [No]
2. Application form …………………………………………………………… [Yes] [No]
3. Provisional degree or diploma or certificate: ………………………………… [Yes] [No]
4. Certificate of Registration ……………………………………………………… [Yes] [No]
5. Certificate from the sponsoring authority:…………………………………… [Yes] [No]
6. Admission letter from the college / hospital where the training
   Is to be scheduled…………………………………………………………….... [Yes] [No]

Signature ______________________________

Dated _________________________________



ACKNOWLEDGEMENT

(to be filled by the candidate)

Received Application from Ms/ Mr.………………………………………………………………

D/o / S/o Sh……………………………………………………....... alongwith Bank Draft/DD

No…………………………… dated..………………………….. for Rs………………………

Drawn on Bank……………………………………………………………………………….

for issuance of Temporary Registration/Permission.

Signature of Receiving Official
with date