Nidaan
Medicare Pvt. Ltd.

Doctor Registration Form

First Name _____ Middle Name _____ Last Name

Date of Birth _____

Specialty _____

Qualification _____ Year of Passing MBBS

Hospital Name _____

Hospital Address _____

City _____ State _____ Pin Code _____

Hospital Telephone Number (with STD code) _____

Residence / Courier Address _____

City _____ State _____ Pin Code _____

Residence / Courier Telephone Number (with STD code) _____

E-mail Address _____

*Medical Practice Registration No. _____ *Medical Registration State

*PAN Number _____

*Consultation Tel./Mobile No. _____

(This is the phone number where you will receive patient calls through Nidaan.
I promise to inform Nidaan immediately if it changes in future.)

*Mandatory Fields.

Provide the copies of the following documents

☐ Photo ID Card (Passport/Driving License) along with the address section. ☐ 2 Passport Size Photos

In the next 15 days of your registration, if you are unable to submit the above documents, your identity may be disabled. Further, no payments will be processed until the documents are received by us.

Consultation Details Weekday_____to_____ Time_____to_____ Rate_____per minute

Terms of Agreement

- I hereby state that I am not debarred by any law from entering into this agreement, if there is any dispute about my competency to enter this agreement, it will be my sole responsibility.
- I agree to abide by all laws of the jurisdiction that I practice medicine in, and to follow the guidelines provided by various governing medical associations/institutions. It is my responsibility to follow these laws as Nidaan just provides a communications channel with my patients.
- Nidaan holds the right to cancel my name from the consultation list, on any grounds whatsoever.
- I hereby undertake that during my consultancy through Nidaan platform, I shall abide by the code of medical ethics as enunciated in the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002 and Hippocratic Oath taken. Nidaan will not be responsible for any Consultancy held by me.
- I hereby undertake, that the information given in this form is true and correct, and that my medical practice license is valid.
- I hereby authorize Nidaan Medicare Pvt. Ltd. to deduct 40% amount + service tax as per Govt. rules & regulations whenever applicable from the credit of my consultancy fees towards handling charges.
- I declare the address given by me is authentic. I undertake to notify Nidaan Medicare Pvt. Ltd. if the address changes, within 15 days of change.
- I authorize Nidaan Medicare Pvt. Ltd. to use my photo on Nidaan website.
- I hereby certify that the phone number that I have provided will be used by me for Nidaan's paid consultation. I will undertake to inform Nidaan Medicare Pvt. Ltd. if there are any changes to this phone number on immediate basis.
- I have read the terms of agreement and agree to abide by them.

Name_____ **Signature**_____ Date_____

Signature should match with ID proof.

Post Address : Nidaan Medicare Pvt. Ltd. 62, Jai Jawan 3, JLN Marg, Jaipur-302018