INTIMATION: CHANGE OF PARENT POLYCLINIC
(Separate form to be raised for each card/copy to be sent to concerned Regional Centre)

To

OIC ECHS Polyclinic
__________________________________________________
__________________________________________________
__________________________________________________(Address of Old Parent Polyclinic)

1. ECHS Card No_____________________________________

2. Name of ECHS beneficiary____________________________

3. Relationship with ECHS Member_______________________

4. No______________________________________________

5. Rank____________________________________________

6. Name of AFV______________________________________

7. Old Parent Polyclinic________________________________

8. New Parent Polyclinic________________________________

9. Date of change of parent Polyclinic____________________

10. Duration from____________________to____________________

Declaration by Card Holder
Certified above is true

Date: ____________________________ (Sign. Of Card Holder)

Remarks of OIC Polyclinic
Verified details as above
Certified above is true

Date: ____________________________ (Sign. Of OIC Polyclinic)