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)