Community Development Medicinal Unit

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
Email: cdmuwb@dataone.in; cdmuwb@yahoo.in
Web: www.cdmuindia.org

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. 500/- [rupees five 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 by Cash / Demand Draft in favor of '*Community Development Medicinal Unit*'. The following documents needs to be attached with the application form:

- ☐ **Photocopy of your Society Registration Certificate**
- ☐ **Latest annual report**
- ☐ **Balance sheet [Optional]**
- ☐ **Photocopy of memorandum of association**
- ☐ **Photocopy / Declaration of 80 G registration certificate**
- ☐ **Photocopy / Declaration of 12 A registration certificate**

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 [available at: www.cdmuindia.org] 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**:

   _____

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

9. **Areas of activity**

☐ Education ☐ Health ☐ Microfinance ☐ Food program ☐ Emergency service ☐ Disaster management
☐ Rehabilitation ☐ Others _____

10. **Type of healthcare provided**: ☐ Hospital ☐ Clinic ☐ Mother & Childcare Centre ☐ Mobile clinic
☐ Others _____

11. **Other information**:

Population covered			
Category of population covered	☐ Above poverty level	☐ Below Poverty level	
Number of staff	Medical staff	Health workers	Pharmacist
Yearly medicine expenditure			
Yearly medicine budget			

12. **In your health program do you have the following**:

☐ Essential Medicine list ☐ Standard Treatment Guidelines

13. **Do you require help from CDMU in conducting research work**: ☐ Yes ☐ No

14. **Do you want to participate in training program conducted by CDMU**: ☐ Yes ☐ No

15. **Do you want to participate in advocacy program conducted by CDMU**: ☐ Yes ☐ No

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Partner membership application form – Page 3

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 _____

Organization official seal

Designation: _____

Signature with Date: _____

For CDMU office use only

Recommended for acceptance by: _____ **Accepted by**: _____

Application receipt date: _____ **Application filed by**: _____

Signature with date