PiCaSoid

The Health Platform for Everyone.

DOCTOR REGISTRATION FORM

NAME OF THE DOCTOR		
DOCTOR DEGREE		
DEGREE FROM		
DEPARTMENT		
SPECIALITY		TOTAL YEAR OF EXPERIENCE:
CURRENT CLINIC		
POST IN CLINIC		
ADDRESS		
MOBILE NO.		ALTERNATE MOBILE NO.:
OTHER PRACTICES (CLINIC NAME AND ADDRESS)		
EMAIL ID		
STATE:	PIN:	DISTRICT:

LIST OF SOFTCOPY REQUIRED TO SUBMIT:

SL. No.	PARTICULAR
1	RECENT PASSPORT PHOTO (SOFT COPY).
2	DEGREE CERTIFICATES
3	PAN CARD
4	AADHAAR CARD

BANK ACCOUNT DETAILS	Account Holder Name: Bank Name: Account Number: Branch: IFSC Code:

OFFLINE CONSULTATION (FACE TO FACE CONSULTATION AT CLINIC/ Hospital):

Consultation Fee (INR):

FACE TO FACE CONSULTATION TIMING		
DAYS	**START TIME**	**END TIME**
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

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ONLINE CONSULTATION (VIDEO & CHAT USING SMART PHONE):

Video Consultation Fee (INR):

VIDEO CALL CONSULTATION TIMING		
DAYS	**START TIME**	**END TIME**
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

CHAT CONSULTATION TIMING:

Chat Consultation Fee (INR):

CHAT CONSULTATION TIMING		
DAYS	**START TIME**	**END TIME**
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

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FREE CONSULTATION TIMING: **Consultation Fee (INR): Rs 0/-**

FREE VIDEO CONSULTATION TIMING		
DAYS	**START TIME**	**END TIME**
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

FREE CHAT CONSULTATION TIMING		
DAYS	**START TIME**	**END TIME**
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

Undertaking

I solemnly state that the information given on this form is true and correct and all the information provided in this form can be use or made available on any PiCaSoid related services. Further, I also state that I am not employed under the state government or central government.

Signature

Date: Place: