



Deva Vidya

Siddha - The Saga of Tradition

Regd. Office: Vizhinjam [Near Kovalam], Thiruvananthapuram, Kerala, S.India, Pin- 695521

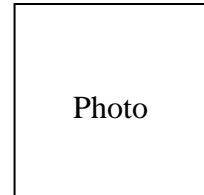
Admin Office : T.K.D Road, East Pattom, Thiruvananthapuram, Kerala, S. India

Tel : + 91- 471-4011110 / 2480620, Help Desk : +91-9895544447

E-mail : info@devavidya.com Web site : www.devavidya.com

DEVA VIDYA CONSULTANTS REGISTRATION FORM

PERSONAL INFORMATION



Name * :

Age * :

Sex * : Male Female

Marital Status * : Married Unmarried

Qualification * : Vaidya BSMS BAMS

*For Vidya attach the copy of experience certificate provided by
Tahsildar (Minimum 5 Years traditional experience.*

Attach the copy of BSMS / BAMS Certificate

Name of Hospital * :

Address * :
.....

City * :

PIN Code :

State :

Country * :

Phone :

Mobile * :

E-Mail ID * :

Website URL (if any) :

Area of Specialization *

(You must Select minimum of any 3 options)

- | | | | |
|--|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Infection | <input type="checkbox"/> Piles |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Eye | <input type="checkbox"/> Infertility | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fistula | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Ayurveda | <input type="checkbox"/> Gall Stone | <input type="checkbox"/> Kshar-Sutra | <input type="checkbox"/> Renal Stone |
| <input type="checkbox"/> Ayurvedic Massage | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Leucoderma | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Beauty | <input type="checkbox"/> Genetic | <input type="checkbox"/> Migraine | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gynae | <input type="checkbox"/> Marma | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Haematology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Sex |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hair | <input type="checkbox"/> Neurology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart | <input type="checkbox"/> Paediatrics | <input type="checkbox"/> Wt. Gain |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Panchkarma | <input type="checkbox"/> Wt. Loss |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Immunology | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Yoga |

Hospital Facilities *

Number of Consultants :

Number of Pay wards :

Number of general wards :

Others :
.....

Service requested from Deva Vidya Team

Medicine : **Yes** **No**

Consultation : **Yes** **No**

Training : **Yes** **No**

DECLARATION

Mr. / Miss. / Mrs. declare as under:

(a) That I am a Traditional Siddha Physician with 5 Years Experience OR Academic Qualified Siddha Physician

(b) I am submitting the attested copy of my experience certificate OR Course certificate along with this application

@ That I solemnly affirm that the above declaration is true and I understand that in the event of declaration being found to be incorrect after my appointment, I shall be liable to dismissed from my service.

Date: (Signature)

Office Use only	
Reg. No:	Date :
Approved Services:	
.....	
Verified by	Authorized Signatory