REGISTRATION FORM FOR MENTAL HEALTH PROFESSIONALS

UNDER SMHA MIZORAM

Name : _____

Father's Name : _____

Date of Birth : _____

Designation : a) Psychiatrist ☐ b) Clinical Psychologist ☐

c) Psychiatric social worker ☐ d) Mental Health Nurse ☐

(e) Others ☐ Please Specify _____

Highest/Professionals Qualification : _____

Registration Number : a) MCI/MSMC _____

b) RCI _____

c) NCI/MNC _____

d) Labour and Employment _____

e) Others (Please specify) _____

Address (Permanent) : _____

Address (Present) : _____

Identification Mark : _____

Blood Group : _____

Epic No : _____

Adhaar No. : _____

Place of Work : _____

Phone No. (Residence, Office & Mobile): _____

Email address : _____

I understand that I will be enlisted as a mental health professional under SMHA Mizoram. I pledge to offer my services as a mental health professional to the best of my ability as and when required by the authority.

Signature and Date : _____

Please submit the above particulars along with one passport size photograph and relevant documents (attested photocopy of Voters ID, Adhaar, Professional Qualification, Registration of appropriate counsel/authority) to the Director (HME) cum CEO (SMHA) at the Directorate of Hospital and Medical Education. Or submit soft copy of the requirements to the following email address mizmentalhp@gmail.com and at Ph No-9862382963.