INSTITUTE FOR HEALTH INSURANCE & MANAGED CARE OF NIGERIA

ONLINE APPLICATION FORM

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Full Member | Graduate | Senior

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DOB | Nationality | State | Telephone

Institute Registration Number | Active E-mail

Name of Next of Kin

Academic & Professional Qualifications

Declaration
I declare that to the best of my knowledge, the information given above is accurate

Signature _____

Thumb Print

Date: _____

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