

E-signed Declaration for Healthcare Professional

Personal Details:

Name: [redacted]

HPR-ID: [redacted]

Professional Category*: [redacted]

Professional Subcategory*: [redacted]

Mobile No*: [redacted]

Email-ID*: [redacted]

Title*: [redacted]

Full Name: [redacted]

Nationality*: [redacted]

Languages Spoken*: [redacted]

Communication Address:

Name: [redacted]

Address: [redacted]

Country: [redacted]

State: [redacted]

District: [redacted]

City/Town/Village: [redacted]

Postal code: [redacted]

Registration Details:

Registered with State Council*: [redacted]

Registration Number*: [redacted]

Registration Date*: [redacted]

Registration Type*: [redacted]

Next Date of Renewal*: [redacted]

Qualification Details:

Name of Degree or Diploma*: [redacted]

Country Name*: [redacted]

State Name*: [redacted]

College Name*: [redacted]

University Name*: [redacted]

Work Details:

Currently Working*: [redacted]

Nature of Work: *: [redacted]

Facility Details:

Current Facility	Facility ID	Facility Status	Name	Address	State	District	Type	Department	Designation	Status
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Declaration

I hereby declare that I am voluntarily sharing above mentioned particulars and information. I certify that the above information furnished by me is true, complete, and correct to the best of my knowledge. I understand that in the event of my information being found false or incorrect at any stage.

Name:

Healthcare Professional ID Number:

Digital Signature:

Digitally signed by
Date: 2026.10.27 16:21:25 IST
Reason: HPR Registration
Location: NHA