CHETTINAD DENTAL COLLEGE AND RESEARCH INSTITUTE

ALUMNI MEDICAL ASSISSTANCE FORM

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| --- | --- |
| **Name of the Alumni** |  |
| Age/gender |  |
| Batch name/Year |  |
| Address |  |
| Phone No |  |
| Medical complaint |  |
| Guided by |  |
| Treatment done |  |
| **Name(Father/ mother/ husband/children)** |  |
| Chief complaint |  |
| Guided by |  |
| Treatment done |  |
| **Name (Father/ mother/ husband/children)** |  |
| Chief complaint |  |
| Guided by |  |
| Treatment done |  |

 **Signature of the alumni Signature of the parent**