To – Director
Medical Supplies Division

# SWASTHA System User Registration Form

**Institution Code & Name**

| | |
|---|---|
| | |

## User Details

| | | | |
|---|---|---|---|
| Name with Initials | | | |
| Full Name | | | |
| NIC | | Mobile No | |
| Designation | | | |
| Email ID | | | |
| Nature Of Duty | | | |

I certify that the above details are true and correct on behalf of my knowledge.

……... ……
Signature Head of the Institution

……... ……
Date Date

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**FOR SWASTHA ADMIN USE**

Approved: ☐ Registered: ☐

Username:

User Role:

Authorized Signature: ……. Signature: …….

Designation: ……. Date: …….