

REGISTRATION FROM

(Fill in Capital letter)

Sponsor ID :														Position :			Left :			Right :		
Upline ID :														Position :			Left :			Right :		
Joining Package :		Basic		Prima		Elite		FeonnaaPathy														

APPLICANT INFORMATION

Individual :		Partnership Firm :		Company :		HUF :		Other :								
(PLEASE PROVIDE RELEVANT DOCUMENT)																
Citation :		Mr.		Mrs.		M/s.		Gender :		Male		Female		Others		
Applicant Name :							Father/Husband Name :									
Applicant PAN No. :								Applicant Date of Birth :	D	D	M	M	Y	Y	Y	Y
Applicant Address (Please Submit Relivant Document):																
City :							Pin Code :									
State :							District :									
Phone No. :							Mobile No. :									
Email ID :																

BANK DETAIL (PLEASE SUBMIT RELEVANT DOUCOMENTS)

Bank Name :																	
Bank Account No. :																	
Bank Branch :													City :				
IFSC Code :																	

NOMINATION DETAIL

Nominee Name:																
Relationship :							D.O.B	D	D	M	M	Y	Y	Y	Y	

DETAIL OF NEW FEONNAAPATHY MEMBER

Name :																
Father's / Husband Name :																

ADDRESS OF NEW FEONNAAPATHY MEMBER

City :							Pin Code :									
State :							District :									
Phone No. :							Mobile No. :									

LIFESTYLE DETAIL OF NEW FEONNAAPATHY MEMBER

D.O.B	D	D	M	M	Y	Y	Y	Y	Age	Height	CM	Weight		Kg.
Blood Pressure :	SYSTOLIC		DIASTOLIC		Sugar		FASTING		POSTPRANDIAL		Diet	Vegetarian	Non-Vegetarian	
1.	Do you currently use any medicine? If yes please specify Disease Name (a)..... (b)..... (c)												Y	N
2.	Have you consulted Doctor in last six months for Indigestion, Constipation, Acidity, Blood Pressure, Heart Disease, Arthritis, Diabetes, Obesity , Cancer & Fever?												Y	N

FEONNAAPATHY DECLARATION

1.	The associate who advice me Feonnaapathy Diet, Suppliments and Lifestyle has elaborated me the entire process of Feonnaapathy.	Y	N
2.	I will follow the Feonnaapathy Diet and Lifestyle as stated in the process. I clearly understand that Feonnaapathy is a combination of Dietary Suppliment and Healthy living lifestyle process. It's not a Medical Treatment.	Y	N
3.	I know well to get result from Feonnaapathy, I must have to follow 21 days Feonnaapathy Diet along with Feonnaapathy Suppliments. If its not follow then the result will vary.	Y	N

FEONNAAPATHY ASSOCIATE DECLARATION

I Mr/Mrs..... hereby declar that I have gone through the Company Feonnaapathy Process Training and I am also a part of Feonnaapathy lifestyle. Before recommending Feonnaapathy lifestyle process to Mr/Mrs I have properly understood his/ her living lifestyle and elaborate him/her the process of Feonnaapathy lifestyle, consumption of Feonnaapathy Suppliments and Feonnaapathy Diet Plan.

ASSOCIATE SIGNATURE		FEONNAAPATHY NEW MEMBER SIGNATURE	
Associate Name :		Member Name :	
Associate Code :		Date :	
Date :		Place :	
Place :			

By signing below I acknowledge that I have read the terms and conditions and that I voluntarily agree of my own free will to be bound by them. I certify that the information provided above herein is correct to the best of my knowledge. The Independent Business Distributor (IBD) ID Number will be provided after the online registration procedure is done.

Signature of the applicant	Place :	
	Date :	

OFFICE USE ONLY

Member ID :														Position :	Right	Left
Prepared By								Approved By								