

## REGISTRATION FORM

Session : \_\_\_\_\_

Course : \_\_\_\_\_

Name : \_\_\_\_\_

Father's Name : \_\_\_\_\_

Address : (Permanent/Postal) \_\_\_\_\_

\_\_\_\_\_

Present : \_\_\_\_\_

\_\_\_\_\_

Affix  
Passport  
Size  
Colour  
Photo

Phone (Resi) : \_\_\_\_\_ (Mobile) : \_\_\_\_\_

Email : \_\_\_\_\_

Graduated from (College/University) : \_\_\_\_\_

Year of Passing : \_\_\_\_\_

Date of completion of Internship : \_\_\_\_\_

Presently working as : \_\_\_\_\_

Fee Details : \_\_\_\_\_ Amount : \_\_\_\_\_

Demand Draft : \_\_\_\_\_ Bank : \_\_\_\_\_

**\* Demand draft to be made in favour of "Delhi Academy of Medical Sciences Pvt. Ltd." Payable at Delhi**

**\* It should be sent 4B, IIIrd Floor, Pusa Road, New Delhi-110005**

**Date :**

**SIGNATURE OF CANDIDATE**