

PC ALLIED HEALTH INSTITUTE

Khongman Zone II, Imphal East, Manipur - 795008

rm No:		<u>APP</u>	LICA	TIO	N F	<u>OR</u>	AD	MIS	SIC	<u>NC</u>					Г		
Course Applied							Enrollment Number :						ick				
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Course Duration	Study	Study Mode				Session						•	ere				
1. [Please f	ill the form u	sing bla	ck bal	lpoint	t per	on	ly & i	n ca	pita	l le	tter]						
Name of the App	licant																
Father's Name																	
Mother's Name																	
Date of Birth				Sex:			M	arita	l Sta	atus	S:	Con	nmur	nity:		Nation	ality:
D D M M Complete For Co	Y E A R] es (Don	't Rep	eat Na	ame)	(U:	se ca	pital	lett	ers	only	()					
												Pos	tal Ci	ty:			
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Mobile:]	ı	E-ma	ail :										
2. ACADEMIC Q Provide complete with those in the	e information	on exa															s must ta
Examination Name of the Passed School			Name of the Board / University				Marks Obtained/ total				Percentage (Aggregate)				& Year of		
			Univ	ersity	<u>'</u>		mar	KS									
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	1																

3.				

Name	Relation	Occupation	Designation	Phone No.

1. REQUIRE DOCUMENT (Enclosed photocopy of certificate, attested by Gazetted Officer):

Sl. No.	Document	Remarks (✓)
1	Aadhaar Card	
2	4 photo passport photo	
3	10 th / 12 th Provisional Certificate /Marksheet/Admit card / Migration.	
4	Income Certificate.	
5	Medical Fitness Certificate.	
6	Aged gap Affidavit certificate, if required.	
7	OBC, SC/ST Certificate.	
8	Domicile Certificate	

2. DECLARATION BY THE STUDENT

- I hereby tender that I will regularly attend the classes and will maintain at least 80% attendance in my class.
- The eligibility documents submitted by me are true and genuine to the best of my knowledge and belief.
- During the course of study I will not be in any kind of regular job either in any Govt., semi Govt. or Pvt. Authority/Co.
- During the course of study I will not do any other regular course from any other institute.
- I will not include in any sort of legal cases, whether Criminal/Civil during the course of study.
- I understand that the fees once paid will not be refunded.
- I will not be involved in malpractice, misconduct, or fraud in any manner during any tenure of study in the institute.

I confirmed that the information given on this form is true, complete and accurate and none of the information requested of other material information has been omitted. I accept if it is discovered that I have supplied false, inaccurate of misleading information, PC Allied Health Institute reserves the right to cancel my application, withdraw its offer of a place or terminate attendance at the PC Allied Health Institute and I shall have no claim against PC Allied Health Institute in relation thereto.

Place:		
Date:	Signature of the Guardians	Signature of the applicant