RABIA MOON MEMORIAL INSTITUTE OF NEUROSCIENCES TRUST

(REGISTRATION FORM)

Date: _____

Elective Dates: From _____ to _____ (4 to 6 weeks min.)

Elective Timings from _____ to _____ (9 to 2) and (2 to 7)

ATTACH
RECENT
PHOTOGRAPH

1. Full Name in capital letters: Mr./Miss./Mrs./Dr. _____
2. Father's / Husband's Name: _____
3. Date and Place of Birth: _____
4. Nationality:_____
5. Religion: _____
6. Residential Address: _____
7. Residence Telephone No: _____
8. Cellular Phone No: _____

QUALIFICATION(S)	YEAR OF PASSING	INSTITUTION

Applicant Signature _____

Administrator_____ **In charge of Department**_____

Note:
This registration is valid for _____ only incomplete application will not be processed.
The elective at the time of joining is required to submit:

- Application
- Registration form :
- NIC copy
- FEE Rs. 2000/-

FOR OFFICE USE ONLY