

RABIA MOON MEMORIAL INSTITUTE OF NEUROSCIENCES TRUST
(STUDENT VOLUNTEERS REGISTRATION FORM)

Date: _____

IT Dept. () **Rehabilitation** () **Kinder Care** ()

Observership: Neurophysiology () **Neurology OPD** () **Laboratory** ()

Date: From _____ to _____ 20 hours min. (2 Hours per day)

ATTACH
RECENT
PHOTOGRAPH
HERE

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

Name of Institute	Grade

Applicant Signature _____

Administrator _____

Guardian Signature _____

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 :
- CNIC of Guardian/Parent
- Student Id Card Copy
- FEE Rs. 1000/-

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