

GUJARAT UNIVERSITY OF TRANSPLANTATION SCIENCES
Ahmedabad

APPLICATION FORM

CERTIFICATE COURSE IN DIALYSIS TECHNOLOGY

APPLICATION NO. _____ }
REGISTRATION NO. _____ } For Office
Use Only

Affix your recent
Passport size,
color
Photo here (with
signature)

01. Name of the applicant (In Block Letters)
(Surname) *(Name)* *(Father's / Husband's Name)*

02. Date of birth _____ 03. Age _____

04. Gender _____ 05. Blood group _____

06. Nationality _____

07. Email ID: _____

08. Phone No. (R.) _____ (M.) _____

09. Languages Known

Languages	Speak	Read	Write

10. Permanent Address _____

11. Address for Communication _____

12. Educational Qualification

S N	Course of Study	Month & Year of Passing	Name of School/ College	Name of Board/ University	Aggregate marks (Write year wise marks)	Remarks

13. Any Awards / Prizes Received _____

14. Details of Form fee Payment

A. D.D. / Receipt No. _____

B. Bank: _____ C. Date _____

D. Amount in Words _____

DECLARATION BY THE APPLICANT / GUARDIAN

I _____ son / daughter of _____, hereby solemnly declare that all information furnished and enclosures given in this application are true and complete to the best of my knowledge and belief. I am also aware that if any statement made herein if found to be incorrect at any time either before or after admission, I will be liable to forfeit my seat and / or removal from the rolls of the College at whatever Stage of study I may be, besides making me liable for criminal prosecution.

Place:

Date:

Signature of Applicant / Guardian

Enclosures

1. School Leaving certificate
2. 12th Science passing certificate
3. Medical Fitness certificate
4. Two passport size photographs

MEDICAL FITNESS CERTIFICATE
To whom so ever it may concern

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This is to certify that I have examined Mr./ Miss. _____ aged _____

He/ she is suffering / not suffering from following diseases

Asthma	Physical Disability
Diabetes	Mental Disability
Hypertension	Allergy

Fits / Convulsions

He/ she has undertaken / not undertaken all vaccination.

Any other major disease (Please specify) –

His/ Her height....., weight....., vision.....,Hearing-----.

I certify that Mr. / Miss _____ is physically, mentally &
Psychologically fit / unfit for _____ course.

Marks of identification

Thumb impression

Signature:

Name of Registered medical practitioner:

Place:

Reg. No.:

Date:

Address:

(Office Seal)