

12. Address for Communication _____

13. Educational Qualification

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

14. Professional Experience

Sr. No.	Name of Organization/Institute	Experience & Designation		Date of Joining	Date of Relieving	Remarks
		Clinical	Teaching			

Specify the clinical areas where you have worked _____

15. Any Awards / Prizes Received _____

16. Details of Entrance Exam Fees Payment

A. D.D. / Receipt No. _____

B. Bank: _____ C. Date _____

D. Amount in Words _____

DECLARATION BY THE APPLICANT

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 is 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

Enclosures

1. B.Sc. mark sheets of all three years
2. University Degree Certificate
3. School Leaving Certificate
4. Experience Certificate
5. Medical Fitness Certificate
6. Two passport size photographs
7. Migration Certificate (if applicable)

CERTIFICATE BY THE PRESENT EMPLOYER

(In case of candidate who is already in service)

This is to certify that we have no objection to the selection of

_____ to the **Postgraduate Diploma In Medical
Laboratory Technology Course** of 1 year duration at IKDRC-ITS, a Constituent
Institute of Gujarat University of Transplantation Sciences (GUTS), Ahmedabad,
Gujarat, India.

**Signature of the employer
with Office Stamp & date**

MEDICAL FITNESS CERTIFICATE
To whom so ever it may concern

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

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)