APPLICATION FORM

FELLOWSHIP IN ____

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

APPLICATION NO. ____________________ } **For Office**

REGISTRATION NO. ____________________ } **Use Only**

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. Marital status ________________

08. E-Mail ID ____

09. Phone No. (R.) ________________________ (M.) __________________________

10. Permanent Address ____

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11. Address for Communication ____

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12. Educational Qualification

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

13. 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 ___________________________________

____

14. Any Awards / Prizes Received ____

____

15. Details of Entrance Exam Fees Payment

A. D.D. / Receipt No. ___________________

B. Bank: _________________ C. Date ___________________

D. Amount in Words ____

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 **Fellowship in** ____________________ ____________________ 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

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 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**

Enclosures

1. MBBS, MD Degree Certificate
2. School Leaving Certificate
3. Experience Certificate
4. Medical Fitness Certificate
5. 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)