



# Integrated Institute of Medical and Health Science

*(Under the Aegis of - Innovative Education and Scientific Research Foundation)*

Near Nawada Metro Station, Pillar No. 733, Gulab Bagh, Uttam Nagar, New Delhi - 110059

Contact: +91-11-41020044, 7903205853, 8826266623, Email: iimhscourse@gmail.com

Website: www.iimhs.org.in

## Application Form

PP Photo

1. Name: \_\_\_\_\_
2. Date of Birth: \_\_\_\_\_
3. Gender: \_\_\_\_\_
4. Father/Husband Name: \_\_\_\_\_
5. Mobile No.: \_\_\_\_\_
6. Alternate No.: \_\_\_\_\_
7. Mother Name: \_\_\_\_\_
8. Email id.: \_\_\_\_\_
9. Occupation: \_\_\_\_\_
10. Marital Status: \_\_\_\_\_
11. Residence Address: \_\_\_\_\_
12. Educational Qualification: \_\_\_\_\_
13. Name of the University/Board: \_\_\_\_\_
14. Passing Year: \_\_\_\_\_
15. Total Marks %: \_\_\_\_\_
16. Course Applied for: \_\_\_\_\_

**DECLARATION**, I Mr./Mrs..... (Name) relation with the applicant ..... declare that IIMHS concern person given complete information about the course and fee and I have understood and satisfied with that. My Son/Daughter/Wife have given above mentioned particulars to the IIMHS are correct and please allow my Son/Daughter/Wife to join above stated Course of the IIMHS and I assure you that my Son/Daughter/Wife will obey the instructions/orders issued by the Principal/Teacher or by any authorized person of the IIMHS. I take responsibility of his/her behavior and payment of course fees on time.

Date.....

Place.....

**Signature**

(Father/Mother/Guardian/Husband)

Name.....

Relationship.....

**Signature of the Applicant**