Skill India
कौशल भारत - कुशल भारत

Healthcare Sector Skill Council

Application form:

Paste your recent passport size photograph

APPLICATION FOR REGISTRATION AS ALLIED HEALTH PROFESSIONAL

Name and Address of the Applicant (In block letters):

Phone Number:

Email Id:

Contact Number:

Blood Group:

Mailing Address:

Date of Birth(mm/dd/yy):

Nationality:

Sex:

Father's Name:

Mother's Name:

Mark at body as identity:

Name & Address of the Institution where education was obtained :

Date of joining for training:

Date of completion for training:

Educational Qualification registration is sought for:

S No	Job Role Name	Batch Start Date	Year of passing with month	Institute Name	PMKVY/NON PMKVY or other (details)

Details of remittance of registration fee (Date and number of receipt or DD Number & Date/NEFT details :

DECLARATION I ....(Name) hereby declare that the statement made in the form are true to the best of my knowledge promise in the event of my being registered and in consideration thereof to be bound by and to conform in all respects to the rules ,regulations etc, Framed by council from time to time in force

Name

Place :

Signature

Date :

Certificate of Attestation

We certify that we are personally acquainted with Ms/Mr. .... D/O W/O S/O .... whose photograph is attested & affixed on this form. She/he undertook a program of (job role name) at... She / he passed the (job role name) .... Examination in the year ....and as per records, She/he bears a good moral character.

Name of tutor...

Signature ....

Name of Principal /.......................................

Signature..........................

Date....../....../......

For Office Use Only

Application Checked by ....

Registration fee paid Vide receipt No...

Date ..../...../........

Registration Number Alloted ....

Date ....

Place...........................

Signature of Registrar: