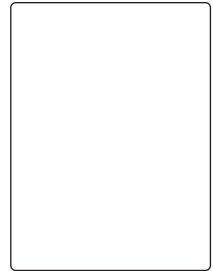




DEVDAHA MEDICAL COLLEGE AND RESEARCH INSTITUTE
 EXTENDED PROGRAMME OF KATHMANDU UNIVERSITY
 SCHOOL OF MEDICAL SCIENCES



ADMISSION FORM

Program Training Site

Surname..... Other Name.....

Date of Birth.....
 Day/Month/Year

Nationality:

Sex: Male Female

Parent/ Guardian's Name:

Relation:

Occupation:

Permanent Address	Corresponding Address
.....
.....
.....

Telephone No : Telephone No :

Mobile: Mobile:

Email : Email :

For Official use only

Date Of Admission:

Name Of the College:

Principal:
 (Signature)

Date :