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 : ……………………………………