



CHRISTIAN MEDICAL COLLEGE

VELLORE – 632 004

POSTGRADUATE DIPLOMA IN FAMILY MEDICINE

APPLICATION FORM

1 Name (As it appears in MBBS certificate)																				
2 Father's Name																				
3 Date of Birth				4 Age	_____ Years															
5 Sex	Male <input type="checkbox"/>		Female <input type="checkbox"/>		6 Date of Birth dd/mm/yyyy															
7 Permanent Address																				
											Pin									
8 Correspondence Address																				
											Pin									
9 Mobile No 1														Landline No:						
Mobile No 2														Landline No:						
10 Email id 1																				
Email id 2																				
11 Name & Complete address of the Institution you are likely to join soon																				
12 Type of Institution	Tertiary Hospital <input type="checkbox"/>				Secondary Hospital <input type="checkbox"/>				Clinic / Primary Care Institution <input type="checkbox"/>				Community Project <input type="checkbox"/>				Others <input type="checkbox"/>			

13 Ownership of the Institution	Mission Hospital	<input type="checkbox"/>	Voluntary	<input type="checkbox"/>
	Govt./ Quasi Govt.	<input type="checkbox"/>	Private Sector	<input type="checkbox"/>
	Others	<input type="checkbox"/>		

14 Do you have a service obligation after internship? Yes No

If you do not have a service obligation, are you willing to work in a clinical facility for the next 1 year? Yes No

Are you planning to pursue a PG course in the next 1 year? Yes No

15 How do you think this course will benefit you?(Attach extra sheets, if needed)

16 What are your long term plans? (Attach extra sheets, if needed)

17 Will you be able to complete the 2 contact courses of 6 days each, work through the 13 course booklets and complete an appropriate project as part of the course requirements? Yes No

I do hereby declare that the information given above is true to the best of my knowledge and belief.

Enclosures: MBBS certificate

Date:

Signature of the Applicant

