Central Board of Community Medical Sciences

An autonomous organization of health education,
Under the aegis of A.B.E.T. Regd. By Govt. of India

C-1/1, 3rd Floor, Dilshad Colony, Delhi 110095, Mobile:- 7289023259 Email:- cmseddelhi@gmail.com

Registration Form

CMSED/P.G.D.P./D.M.L.T./D.P.T./C.C.H./C.G.O./C.S.D./D.D.H.T./C.M.A.S.K./B.E.H.M./M.D.AM/H

S.No..... Regd. No.....

To,

Registrar/Secretary
Central Board of Community Medical Sciences
C-1/1, 3rd Floor, Dilshad Colony Delhi

Sir,

I hereby, request that my name and other particulars as mentioned below to be entered in the record registered of CBCMS Medical Board. I enclose Registration Fees Rs. 3000/- By Cash/Transfer Date.....

1	Name (in block letters)				
2	Father's Name (in block letters)				
3	Mother's Name (in block letters)				
4	Postal Address	Moh.		Village	
	Post Office			Distt.	
	Pin Code		State		
5	Date of Birth		Nationality		
	Mobile No.				
6	Name of Institute				
7	Attach Qualification's Details & Enclose: Attested Copies				
				Year:-	

Enclosed Here With:-

(i) A copy of my birth certificate/matriculation/secondary certificate/secondary school leaving certificate.

(ii) Attested copies of certificate of the Diploma and Certificate courses as required.

Declaration

I agree with the Constitutional rules and by-laws of the Board and respect its ethics and principles. I certify that all the particulars furnished above, are true to the best of my knowledge and belief. Understand that my candidature may be liable to be cancelled if my documents or any activities proves misleading and affects the goodwill of the Board.

Date..... Signature of the applicant

For office use

Name of Student.....Father/Husband's Name.....
Received application on Date..... Rs..... By Cash/Transfer.

Note:- Incomplete form will be rejected without any notice. Registrar/Secretary