

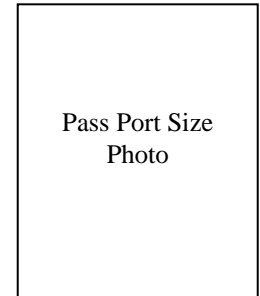
GOVERNMENT MEDICAL COLLEGE & HOSPITAL, CHANDIGARH

Application Form for Short-Term Training (Two months) in the
Department of Psychiatry

1. Name of the Candidate : _____
2. Father's Name : _____
3. Date of Birth : _____
4. Address for Correspondence : _____

5. Permanent Address : _____

6. Telephone/Mobile No. if any : _____
7. E-mail, if any : _____
8. Education Qualifications : _____



Sr. No.	University/College	Year of Passing	Marks Secured	Max. Marks	%age

8. Category : _____
9. Details of enclosed draft : Amount Rs. _____
D.D. No. _____ Dated _____
Bank: _____

Signature of Applicant