  

# Application form for

 **Post Graduate Diploma in Clinical Research (PGDCR)**

**Permanent**

**Address:**

**Current Address:**

**Father’s/Husband’s Name:**

**Father’s/Husband’s Contact Number:**

**Email Id:**

**Mobile no:**

**YY**

**MM**

**Last Name**

**DD**

**First Name Middle Name**

**Male Female Date of Birth:**

**Name:**

**Gender:**

**Dr.**

**Ms.**

**Mr.**

**Title:**

**Personal Details**

*ATTACH PHOTOGRAPH*

* Please enclose DD/or online bank transfers, UPI payment for **₹** 500/-
* Attach copies of the provisional mark sheets and degree certificates.
* The candidate is informed that if after proper scrutiny of his/her application form the details furnished is found incorrect, the candidate is liable to forfeit admission no matter at what stage of the course he/she will be at that time.

**INSTRUCTIONS**

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| **Educational Details** |
| **Course** | **Year of completion** | **University** | **Percentage** |
| **PG (if any)** |  |  |  |
| **Graduation** |  |  |  |
| **Intermediate** |  |  |  |
| **High School** |  |  |  |

  

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| **Professional experience (if any)** |
| **Company** | **Date of Joining** | **Duration** | **Designation** |
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## DECLARATION

I hereby declare that the particulars given above are true and correct to the best of my knowledge.

Further, I undertake to abide by the rules and regulations of the Institute in force as amended from time to time. I am aware that any violation of the rules and regulations will result in the forfeiture of my right to continue the course.

**Date:**

**Place: Signature of applicant**

**Contact Details**

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| **Apollo Hospital: New Delhi**Dr. Sunita Kumari+91 11 2682 5612, 4140 2511(M) +91 9953430065;9560054650E-mail: sunita.k@apolloari.com; sunita.k@aherf.net; |  **DPSRU**Dr. Mukesh Nandave  Phone: +91 11 29553771  (M) +91-7208093539 E-mail: mukeshnandave@gmail.com |