

Rabindra Memorial Healthcare Foundation



Conducted by
INDIAN RURAL MEDICAL ASSOCIATION
 Centre 67



Session -

(Must fill in BLOCK LETTERS)

Affix
 PASSPORT
 SIZE PHOTO
 and attach

1. Name of the Candidate:.....
2. Father's/Husband's Name:.....
3. Postal Address:
- Vill:-..... P.O:-.....
- Block :-.....Pin:-.....Dist:-.....
4. Sex: M / F 5. Merital Status: Single / Marred
5. Blood Group:..... 6. Date of Birth:
7. Academic Qualification:
9. Mood of Training : Institutional / Correspondence
8. Occupation:
9. Nationality :
10. Academic records details: (Attach certificate photo copy)

EXAME PASSED	NAME OF BOARD/ COUNCIL/UNIVERSITY/ANY OTHER	MARKS OBTAIN	YEAR OF PASSING
10 th			
12 th			
Last Qualification			

11. Personal Contact number:
12. Email id :.....

❖ Enclosures :-

Photocopy of Mark Sheet duly attested by Gazetted Officer and Programme Co-ordinator.

1. Mark Sheet of last Qualifying exam (2copy).
2. verification passed for verification of Minimum Eligibility. (2 copy)
3. High School Certificate (10th Level) or Admit card for date of birth.(2copy)
4. Aadhar card (1copy)
5. Any other medical training certificate.(1copy)

❖ **DECLARATION :**

I hereby declare that the above statement is true to the best of my knowledge and belief. I have read the prospectus and understood the rules and regulations of the organization regarding the C.M.S & E.D courses and I will follow the same rules & regulations and others as and when changed by the organization.

I know well that Indian Institute for Health Training- is an autonomous institution and functioning without taking any grant from govt .The Training Institute, Conducted by –Indian Rural Medical Association, Kolkata. Regd by Govt of WB , Constituted Under the IR Act-1908. Running Primary Health Care Course through IIHT under Article 14,15,19(1),21,26,29,30,45,46 & 351 of The Constitution of India .Indian Institute for Training (IIHT) never Given guaranteed for Validity of Jobs as further education on completion of Concern Courses –cms & edt. All dispute will be settled at West Bengal Jurisdiction only .

I have read and understood the rules and regulation of The Training Institute and shall abide by them .

Yours faithfully

Date :-

Place:-

Full signature of Candidate

❖ **Cancellation of Admission & Refund Policy :**

Fee once paid not refundable or adjustable under any circumstances in future. Your admission will be cancelled :

- a) if the admission form is incomplete
- b) if the fee paid is short
- c) if the supporting documents are not complete
- d) if false documents have been submitted
- e) if required educational qualification are not fulfilled
- f) if incorrect wrong information is given I have read and understood the rules and regulation

Date : -

Full signature of Candidate

HEAD OFFICE COPY

For Office Use:
MPD No.....
Date: / /

Registration Form
Indian Rural Medical Association

226 B.B. Ganguly Street. Kolkata-700012

Center No 67.

Session- 20
Must fill in BLOCKLETTERS

FORM-F

PASSPORT
PHOTO

1. Name of the Candidate.....
2. Father's/husband's Name.....
3. Correspondence address.....
Village..... Post Office..... Via.....
District..... State..... PIN Code.....
4. Permanent address.....
Village..... Post Office..... Via.....
District..... State..... PIN Code.....
5. Sex (Male/Female)..... 6. Date of Birth.....
7. Special mark of Identification.....
8. Specimen signature.....
9. Academic Qualification (Last Passed) : (a) Examination.....
(b)Board /University.....(c) Year of Passing.....

Signature of Centre Organiser
With office Seal

Date.....

Signature of the Candidate

ORGANISERS' COPY

For Office Use:
MPD No.....
Date: / /

Registration Form
Indian Rural Medical Association

226 B.B. Ganguly Street. Kolkata-700012

Center No 67.

Session- 20
Must fill in BLOCK LETTERS

FORM-F

PASSPORT
PHOTO

1. Name of the Candidate.....
2. Father's/husband's Name.....
3. Correspondence address.....
Village..... Post Office..... Via.....
District..... State..... PIN Code.....
4. Permanent Contact Number.....
5. Sex (Male/Female)..... 6. Date of Birth.....
7. Special mark of Identification.....
8. Specimen signature.....
9. Academic Qualification (Last Passed) :(a) Examination.....
(b)Board /University.....(c) Year of Passing.....

Signature of Center Organiser
With office Seal

Date.....

Signature of the Candidate

LETTER OF UNDERTAKING

FORM-B

TO WHOM IT MAY CONCERN

Dated.....

Re: CMS-ED/Training of IRMA, Kolkata

I have read and understood the Rules, Regulation and Directives of Indian Rural Medical Association (IRMA) and I promise to obey and abided by all of them at the time of training and after completion of the training i.e.at the time of offering service to the people.

❖ *I further declare the following: -*

1. That I know well that the course for which I have enrolled myself is a certificate course of primary health worker under the guideline of W.H.O.

2. That I know, believe and promise that I will not claim for any appointment or job after completion of the course /Training as I know well, that the course is completely for a health worker for making people health aware and help to maintain primary health care program of the country.

3. That I promise not to introduce and call myself Doctor and / or put the sign or word to denote Dr.(Doctor) before my name to misguide people. If I do so for my any such wrongful act IRMA and/or other authority involved in this training will not be liable at all any manner.

4. That I promise to pay the admission fee, tuition fee and examination fee etc. prevailing or as modified from time to time as course /training fee payable by me as prescribed by IRMA/local committee.

5. That I also declare that if any problem/ dispute arise in connection with this training will be solved at the centre/ organizer level. The organizer / Centre will be the highest authority for solving any sort of disputes and I agree to obey and abide by the decision and rulings of the Centre of IRMA as final.

6. Finally I solemnly declare that I will not misuse any way the motto of the training and in manner at the time of dealing, counseling and providing primary health care to the people.

7. I will renew my MPD number at specified Interval of time abiding the rules of the organization so long I will offer service after passing and my failure to renew the MPD No. in time may make my name to be removed from the central register.

8. I have read the prospectus and understood the rules and regulations of the organization regarding the CMS & ED courses and I will follow the same rules & regulations and others as and when changed by the organization.

I remain, yours faithfully

Signature of the student
MPD NO.-
Centre No. -67

Essential Drugs training for Primary health Care (W.H.O)



INDIAN RURAL MEDICAL ASSOCIATION



226, B.B. Ganguly Street, Kolkata-700012

M.P.D. NO.				
1				
Session	January/July-20			

Center No -067
(Must fill in BLOCK LETTERS)

photo

1. Name of the Candidate.....
2. Father's/husband's Name.....
3. Correspondence address.....
 Village..... Post Office..... Via.....
 District..... State..... PIN Code.....
4. Permanent address.....
 Village..... Post Office..... Via.....
 District..... State..... PIN Code.....
5. Sex (Male/Female).....
6. Date of Birth.....
7. Special mark of Identification.....
8. Candidate is practicing(yes/no) 9. Place.....
10. Academic Qualification (Last Passed) :
 (a) Examination.....(b) Board /University.....
 (c) Year of Passing.....(d) Percentage.....
11. Personal Contact number:

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❖ DECLARATION :

I hereby declare that the above statement is true to the best of my knowledge and belief. I have read the prospectus and understood the rules and regulations of the organization regarding the ED Training for Primary Health Care and I will follow the same rules & regulations and others as and when changed by the organization.

Signature of Center Organiser
With office Seal

Date...../...../.....

Signature of the Candidate