APHETA
INSTITUTE OF CLINICAL RESEARCH
ISO 9001: 2008 Certified

Head Office: 201, 2nd Floor, South Ex. Tower,
Masjid Moth, South Ex. Part – II, New Delhi – 110049
Ph.: 011- 45782279
Website: www.aicrindia.com
Email : enquiry@aicrindia.com

Post Graduate Diploma in Clinical Data Management

REGISTRATION FORM

1. PERSONAL DETAILS

Name

Address

Affix Your Passport size Photograph

City

State **Pin**

Tel **Mob**

Date of Birth Day Month Year **Email:** ……………………………………………..

2. ACADEMIC QUALIFICATIONS (Most Recent First)

Degree	Institution/University	Year	Specialization	Percentage

3. WORK EXPERIENCE IF ANY (Most Recent First)

Name of the Organization	Period of Employment	Designation	Nature of Job

4. PAYMENT DETAILS

DD ☐ **CASH** ☐ **CHEQUE** ☐

DD/Cheque No. : ………………………… Bank Name: …………………………… City: ………………...

5. CHECK LIST TO SUBMIT THE REGISTRATION FORM

1. Photocopy of your marks card/certificate of your graduation/post graduation.
2. 31000 INR (Registration fees of 1000 INR + Seat Booking fees 30000 INR) in DD/CHEQUE/CASH in favors of "APHETA EDUCATIONAL TRUST, New Delhi" Payable at New Delhi India.

ISO 9001: 2008 Certified

Head Office: 201, 2nd Floor, South Ex. Tower,
Masjid Moth, South Ex. Part – II, New Delhi – 110049
Ph.: 011- 45782279
Website: www.aicrindia.com
Email : enquiry@aicrindia.com

Post Graduate Diploma in Clinical Data Management

REGISTRATION FORM

6. DECLARATION: The above information provided by me is true and valid. APHETA INSTITUTE OF CLINICAL RESEARCH provides Placement assistance but will not be held responsible for my terms of employment. I understand that APHETA INSTITUTE OF CLINICAL RESEARCH is committed for delivering effective training and support.

DATE: ……………………………

Place: ……………………………..

Signature of Applicant

FOR OFFICE USE ONLY

Date: __________________ Amount Received: ________________

☐ Cash
☐ Demand Draft No.
☐ Cheque No.

From: _________________________________ for Registration in Post Graduate Diploma in Clinical Data Management, Reg. No.: _____________ Money Received by: ____________________________________

Signature ______________________________

Please send this completed application form along with your applicable program fee to **Apheta Institute of Clinical Research, 389, South Ex. Tower, 201, 2nd Floor, Masjid Moth, South Ex. Part – II, New Delhi – 110049 (India)**