

Post Graduate Diploma in Clinical Research (Part Time)
REGISTRATION FORM

1. PERSONAL DETAILS

| | | | | | | | | | | | |
|----------------------|----------------------|----------------------|----------------------|--|---------------------|------------|----------------------|--|--|--|-------------------------------------|
| Name | <input type="text"/> | | | | | | | | | | Affix Your Passport size Photograph |
| Address | <input type="text"/> | | | | | | | | | | |
| | <input type="text"/> | | | | | | | | | | |
| City | <input type="text"/> | | | | | | | | | | |
| State | <input type="text"/> | | | | | Pin | <input type="text"/> | | | | |
| Tel | <input type="text"/> | | | | | Mob | <input type="text"/> | | | | |
| Date of Birth | <input type="text"/> | <input type="text"/> | <input type="text"/> | | Email: | | | | | | |
| | Day | Month | Year | | | | | | | | |

2. ACADEMIC QUALIFICATIONS (Most Recent First)

| Degree | Institution/University | Year | Specialization | Percentage |
|--------|------------------------|------|----------------|------------|
| | | | | |
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| | | | | |

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. Registration fees of 1000 INR in DD/CHEQUE/CASH in favour of “APHETA EDUCATIONAL TRUST” Payable at New Delhi India.



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

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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 PGDCR (Full time). Reg. No.: PGD _____

Money Received by: _____ Signature _____

Please send this completed application form along with your applicable program fee to **Apheta Institute of Clinical Research, No: 201, 2nd Floor, South Ex. Tower, Masjid Moth, South Ex. Part – II, New Delhi – 110049 (India)**