

Post Graduate Diploma in Clinical Research (Distance Learning)
REGISTRATION FORM

1. PERSONAL DETAILS	
Name <input style="width: 100%;" type="text"/> Address <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> City <input style="width: 100%;" type="text"/> State <input style="width: 100%;" type="text"/> Pin <input style="width: 100%;" type="text"/> Tel <input style="width: 100%;" type="text"/> Mob <input style="width: 100%;" type="text"/> Date of Birth <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> Day Month Year </div> Email:	Affix Your Passport size Photograph

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 <input type="checkbox"/> CASH <input type="checkbox"/> CHEQUE <input type="checkbox"/>	
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 20000 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 Post Graduate Diploma in Clinical

Research (Distance) 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)**