

APPLICATION FORM

MARIAN INSTITUTE OF HEALTH CARE MANAGEMENT

Agnel Technical Education Complex, Verna - Salcete - Goa 403 722

POST GRADUATE DIPLOMA IN HEALTH CARE MANAGEMENT

1. Name: _____
Surname First Name Middle Name

2. Date of Birth: ____ - ____ - ____
DD MM YYYY

3. Address for correspondence : _____

Ph:() _____ Mobile _____

Email: _____

4. Permanent Address: _____

Ph:() _____ Mobile _____



5. Education (Please give the aggregate percentage obtained)

| | Year of Passing | Main Subject | Name of School/ College/ University | Place / City | Percentage |
|------------------|-----------------|--------------|-------------------------------------|--------------|------------|
| High School | | | | | |
| High Secondary | | | | | |
| College (Degree) | | | | | |
| Others* | | | | | |
| | | | | | |
| | | | | | |

* Other academic Degrees/ Master degree/Diplomas (Specify).

6. Work Experience: (If any):

| Organization | Place | Nature of Work | From: Month Year | To: Month Year |
|--------------|-------|----------------|------------------|----------------|
| | | | | |
| | | | | |
| | | | | |

Submit copies of the academic and experience certificates along with the form.

(P.T.O)

7. Test taken: _____

8. How did you come to know of this programme? *(Please tick the applicable option)*

Institute website/general website/newspaper/magazine/other

Please state the name of the website/newspaper/magazine/other source _____

9. What do you expect from this programme?

I confirm that to the best of my knowledge, the information contained in this application is complete and accurate. The information provided in this application may be used as part of my student record.

Date: _____

Signature: _____

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For Office use only :

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|--|--|------|--|---------|--|
| Payment received in Cash/DD/Cheque No: | | Date | | for Rs. | |
| Drawn on (Bank): | | | | | |