ALL INDIA COUNCIL FOR PARAMEDICAL PROFESSIONALS

ADVANCING, INSPIRING, CONNECTING PARAMEDICAL PROFESSIONALS

Date : - ...../...../.....

Membership/Registration Form

Passport Size Photo

To

The Registrar,

All India Council for Paramedical Professionals

Application for Registration of (Course Name): _____

_____

Applicant Details

Name of the Applicant	
Father's Name	
Date of Birth	
Gender	
Aadhaar Number	
Nationality	
Permanent Address with Pin	
Correspondence Address with Pin	
Mobile/Phone	
Email ID	

Details of Educational Qualifications Prior to/Other than Allied and Healthcare Qualifications

Educational Qualification	Name of School/College	Board/University	Year of Passing
Matriculation or Equivalent			
Senior Secondary or Equivalent			

Details of Allied and Healthcare Qualification for Which Registration is Applied

Name of Course	Name of University/College	Duration of Course	Date of Admission	Date of Passing Year

Payment Details

Date of Payment	Amount Paid	UTR No.

Declaration by the Applicant

I have read and understood the council's rules and regulations and provided accurate information and documents. I agree to submit any additional documents if required. I know that my registration may be cancelled, and appropriate action may be taken if the provided information is incorrect or misleading.

Signature of the Candidate

For Office Use Only

Date	UTR No.	Registration Fee	Registration No