BANGALORE CITY COLLEGE OF NURSING

Affiliated to Rajiv Gandhi University of Health Sciences, Bangalore
APPROVED BY THE GOVT. OF KARNATAKA &
Karnataka Nursing Council

APPLICATION FORM FOR M.Sc. NURSING

1. Name of the Candidate ---
   (In Block Letters)
2. Father's / Guardian's Name:- ....

3. Father's / Guardian's Occupation:-...

4. Father's / Guardian's Income :-..

5. Sex:-......................................   **PHOTO**

6. Postal Address for Communication ………………………………………….
…………………………………………………………………………………………
…………………………………………………………………………………………
Phone: STD.Code.-
7. Permanent Address:-
....
....
Phone:-
8. Local Guardian's Address:-
....
....
Phone:-
9. a. Date of Birth-------------------------------------
   b. Place of Birth----------------------------------
10. Year of Passing B.Sc Nursing:-...
11. a. Marks obtained in B.Sc Nursing: Max   obtained
                              I Year   --------   ---------------
                              II Year   --------   ---------------
                              III Year   --------   ---------------
                              IV Year   --------   ---------------
    b. Total Percentage in B.Sc Nursing   --------   ---------------

12. a. Religion -------------------------   b. Cast-------------------------------------

13. a. Nationality: ---------------------   b. Domicile status------------------------

DECLARATION BY THE APPLOCANT AND PARENT / GUARDIAN

Dear Sir,
    I have gone through the College Prospectus, do here by promise to abide by all rules and regulations now inforce and those to be made from time to time. I know that the fee paid by me is not refundable, transferable or adjustable to other parts or subjects. I request you to admit me as one of the student of Bangalore City Group of Institutions.

Signature of Parent/ Guardian   Signature of Applicant

(MEDICAL EXMINATION)

Height ---------------------Weight ------------------- Sight: -------------------Teeth: ----------------

Lungs------------------- Vaccinated ---------------Hearings------------Blood Group-------------

Weather the Candidate has suffered from any of the following:

(a). T.B. --- (b). Rheumatic Fever ------------------------
(c). Mental/Nervous Disorder----------------------- (d) Varicose Veins---------------------------
(e). Rheumatism -------------------------------------- (f) Cardiac Disease---------------------------
(g) Gynecological abnormalities------------------- (h) Dental ----------------------------------

ALLERGIC TO:

REMARKS:

This is to certify that, I have examined Mr. /Miss. --- and that
He / She does not have any disease constitutional weakness or bodily infirmity in
her/him. I consider her/ him to be fit to undergo the above mentioned course.

Date----------------------
Place--------------------   Seal & Signature
                                                                    of Medical Practitioner

                                                                          Reg.No.

FOR OFFICE USE ONLY

Provisionally admitted to the above Course from the Academic year 200   -200

                                                    Verified Original Certificates
                                                    10th Marks Card
Admission No.   PUC/PDC/+2 Marks Sheet
                                                    B.Sc Nursing Marks Sheet
                                                    Transfer Certificate
                                                     Migration Certificate
Date of Admission: Certificate Conduct

        Secretary   **Principal**