

FORM- 3

(See Rule 28, 29 (ii))
Arunachal Pradesh Medical Council

APPLICATION FORM FOR CONTINUATION OF NAME IN THE REGISTER

Receipt No.....

Date.....

(For office use)

To,

The Registrar
Arunachal Pradesh Medical Council
Naharlagun

Affix passport size
photograph attested

Sub:- **Continuation of name in the Register**

Sir,

I request that my name may be continued in the State Register maintained by Arunachal Pradesh Medical Council.

1 Name of the Applicant (in block letters) :

2 Mother's Name :

3 Father's/ Husband's Name :

4 Gender :

5 Date of Birth (date, month, year) :

6 Nationality :

7 Category (General / APST) :

8 (a) Residential Address :

(b) Permanent Address

(c) Professional Address :

9 Telephone No./ Mobile No./ Fax No./
E-mail ID :

10 Details of Qualifications :

Sl. No	Description of Qualification	Name of the School/ College/ Medical Institution/	Name of the Board/University/ Licensing body	Year of the completion of Internship in case of MBBS in any other case year of passing examination.

11 Arunachal Pradesh Medical Council :
Registration Certificate No. & Date

12 Present Occupation :

I submit herewith original certificates for verification and submit attested copies of the same certificates:-

- Two recent passport size photographs with name and signature at the backside.
- Arunachal Pradesh Medical Council Registration Certificate.
- MBBS Degree/ Post Graduate Degree/ Diploma/ Post-Doctoral Degree Certificate.

I hereby submit a Bank Draft No..... Dated Prepared from (Bank).....for Rs.2000/- (Rupees two thousand) as non-refundable fee in favour of "Arunachal Pradesh Medical Council" payable at Naharlagun.

(in case of late fee)

I hereby submit a Bank Draft No.....Dated prepared from (Bank)for Rs..... being the late fee as non-refundable in favour of "Arunachal Pradesh Medical Council" payable at Naharlagun.

DECLARATION

I solemnly affirm and declare that the particulars furnished above by me are true to the best of my knowledge and belief and I undertake to abide by the code of conduct & Ethics of Arunachal Pradesh Medical Council and Indian Medical Council and by the Rules of Arunachal Pradesh Medical Council.

Date :

Signature of the Applicant

(for office use only)

Received the above documents in original.

Signature of registered person.....

Name

Date.....
