



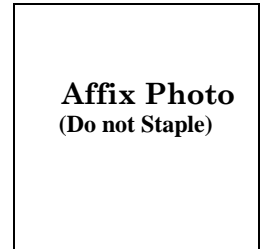
Shija Hospitals & Research Institute Pvt. Ltd
Healthcity, Langol, Imphal West-795004, Manipur.(India)



SKILL DEVELOPMENT TRAINING FORM

Name of Vocational Course:

1. Full Name : -.....
2. *Date of Birth : -.....Age
3. Father's Name : -.....
4. Gender: -.....
5. Email Id. :-.....
6. Mobile No. :-.....
7. Aadhaar No. :-.....
8. Educational Qualification: -



Sl.No.	Qualification	Year of Passing	Division/Grade

9. Permanent Address: -

Village:Town/ City :-.....
District :.....P.S.:.....
P.O.:.....
Pin Code :..... State:.....

10. Correspondence Address: -

Village:Town/ City :-.....
District :.....P.S.:..... P.O
:.....
Pin Code :.....
State:.....

DECLARATION

I, hereby declare that the above information provided by me are true to best of my knowledge. If any mismatch occurs during the verification my candidature can be rejected.

Signature of the Applicant

* Birth Certificate / Matriculation Certificate / SSC Exam Certificate with date of birth.