Application for Admission to
FELLOWSHIP PROGRAMME IN CRITICAL CARE MEDICINE IDCCM

NAME (Dr. ..........................................................)
As written in Final Year Marks Card) ..........................................................

To

The Principal
M S Ramaiah Medical College,
Bangalore – 560 054

Sir,

I wish to apply admission to the under mentioned POST – GRADUATE COURSE in
FELLOWSHIP PROGRAMME IN CRITICAL CARE MEDICINE IDCCM

1. I agree to undergo the course on a full time basis and shall not engage myself
in private practice or consultation of any kind during the period of the
course.

2. I agree that during my stay at the College, I shall not draw any
pay/allowance or fellowship from other sources than permitted by the
College.

3. If I withdraw before completing the course, to continue or join a P.G. Course
else where I agree to return all the allowances paid to me till the date of my
withdrawal and to forfeit all deposits paid by me to the College.

4. I agree to abide by the rules and regulations of this college which governs all
students.

Place: Sincerely

______________________________ __________________________
(Signature of Parent / Guardian) (Signature of the Applicant)

Please Note: All details in this Application Form shall be completed by the
Applicant in his/her own hand writing and in BLOCK LETTERS.
STUDENT PARTICULAR

1. Name in full : Dr…………………………………………..

2. Sex :
3. Date of Birth :

4. Place and State of Birth :

5. Religion / Caste / Sub-caste :

6. Nationality :
7. Single or Married :

8. Permanent Address :

Tel. If any    CODE NO.
Mobile No. :

9. Present Address for correspondence :

SECTION – II: FAMILY PARTICULARS

10. Name of Father / Mother / Guardian :
    Husband
    Tel. If any    CODE NO.
    PHONE No. :
    Occupation :
    Annual Income :
    Total Annual Income of the Family :
    Full Address :
    Pin code :
    E-mail :
    Phone No / Fax :
SECTION – III QUALIFYING EXAM PASSED (MBBS)

11. Name of the College: 
   Name of the University: 
   Reg. No.: 
   Month & Year of Passing: 

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TOTAL

SECTION – IV: EXPERIENCE

13. a. Internship of one year at Hospital (MBBS Degree): 
   b. Date of Completion of Internship from ............... To .............

Name of the State Medical Council where Registered (MBBS Degree): 
Registration Number: 
Date of Registration: 

SECTION V  POST GRADUATION PARTICULARS

14. Post Graduate (MD/MS): 
   SUBJECT

   A. Name of the College: 
   B. Name of the University: 
   C. Year of joining: 
   D. Month & Year of passing: 
   E. Regn. No.: 
   F. Attempts: 
15. Distinctions, Merit scholarship : Medals, Prizes, Honours 

16. Name of the State Medical council :  
Where Registered (MD / MS) :  
Council Registration Number :  
Date of Registration :  

**SECTION –VI OTHER PARTICULARS**

17. Details of Publications and Research Papers :  

18. Details of any Fellowships/ stipend applied for or awarded or likely to be awarded in the near future :  

19. Are you employed? If so, give name and address of your employer, capacity in which employed and the nature of work in which engaged :  

20. Are you being officially sponsored or deputed for this training by your present employer?  
a) If yes, give details of deputation study leave, leave with pay, leave without pay etc. :  
b) If no, Will you resign your job to join the Course? :  

21. Name and address of two responsible persons (Relatives) who could be informed in case of emergency :  

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Phone Code:  
Phone:  

Phone Code:  
Phone:  

(Signature of Applicant)
SECTION V – EXTRA CURRICULAR ACTIVITIES

12. Have you participated in the following activities during the Course
   a) Games and Athletics
      Yes / No (If yes, Specify and enclose copies) :  
   
   b) Social Service / Community Service
      Yes/No (If yes, Specify and enclose copies) :  
   
   c) Cultural activities / (Music, drama etc.)
      Yes / No (If yes, specify and enclose copies) :  
   
   d) Others :  

SECTION-VIII: RURAL SERVICE

13. Have you served in any one of the following area? :
   a) Rural Area  
   b) Was it private practice or in a Hospital? :  
   c) If Hospital, give names and Address  
      i) Name  
      Address  
      Pin Code  
      Period of Service: From ......................... To .................................................  
   d) Any other information that you would like to give  
      Regarding (a) to (d) of above
Certified that Dr. .................................................................
has been selected for Admission to P.G. Course in Fellowship Programme in
Neonatology ..................................Under Management quota / Govt. quota
..................................................Category .................................Batch ..............................

CASE WORKER  SECTION OFFICER

ACCOUNTS SECTION

Certified that the above candidate has paid that College fee of Rs.................
vide Receipt No........................... on............................

CASE WORKER  SECTION OFFICER.

CERTIFICATION

The admission of the above student to the P.G. Course is in order.

REGISTRATION  PRINCIPAL