

APPLICATION FORM
FOR CLINICAL CONTACT LENS PRACTICE COURSE

CONTACT LENS DEPARTMENT
GANDHI EYE HOSPITAL, ALIGARH.

From 08-07-2024 to 12-07-2024.

Ref.No.....

Date.....

(Please read instructions carefully before filling this form)

1. Name

2. Age/Sex.....

3. Date of Birth

4. Father's/Guardian's Name.....

5. Postal Address.....
.....
.....

6. Pin Code No.....



7. QUALIFICATIONS:

| <u>Name of Institution</u> | <u>Year of Passing</u> | <u>Duration of Course</u> | <u>Name of Degree/Diploma</u> |
|----------------------------|------------------------|---------------------------|-------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

8. EXPERIENCE :

9. Name & Address of Sponsoring/Forwarding Authorities

10. Particulars of Bank Draft enclosed :

Bank Name Branch.....

D.D.No..... Date.....

Amount

This is to certify that the instructions given above is correct to the best of my knowledge.

Date.....

[Handwritten Signature]
20-6-24
CANDIDATE'S SIGNATURE

APPLICATION FORM
FOR CLINICAL CONTACT LENS PRACTICE COURSE

CONTACT LENS DEPARTMENT
GANDHI EYE HOSPITAL, ALIGARH.

From 08-07-2024 to 12-07-2024.

Ref.No.....

Date.....

(Please read instructions carefully before filling this form)

1. Name

2. Age/Sex.....

3. Date of Birth

4. Father's/Guardian's Name.....

5. Postal Address.....
.....
.....

6. Pin Code No.....



7. QUALIFICATIONS:

| <u>Name of Institution</u> | <u>Year of Passing</u> | <u>Duration of Course</u> | <u>Name of Degree/Diploma</u> |
|----------------------------|------------------------|---------------------------|-------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

8. EXPERIENCE :

9. Name & Address of Sponsoring/Forwarding Authorities

10. Particulars of Bank Draft enclosed :

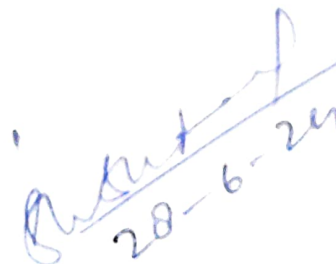
Bank Name Branch.....

D.D.No..... Date.....

Amount

This is to certify that the instructions given above is correct to the best of my knowledge.

Date.....


CANDIDATE'S SIGNATURE
28-6-24

INSTRUCTIONS:

1. Kindly fill this form in block capital letters in neat handwriting or type.
2. Please send duly completed application form to the **Head of Contact Lens Department, Gandhi Eye Hospital, Ramghat Road, Aligarh-202001** alongwith Photostat copies of Certificate of professional qualification and High School Certificate.
3. The candidates must bring Original Certificate for verification on during course period.
4. **This application should reach us before 30-06-2024. Late and incomplete application will not be entertained.**
5. **Please enclose a Bank Draft for Rs. 7,500/- in favour of Gandhi Eye Hospital Trust, Aligarh as Registration fee for this course which is non refundable.**
6. Head of Contact Lens Deptt. Gandhi Eye Hospital, Aligarh may reject or refuse any application without assigning any reason.
7. Only first 30 applications with Registration fee will be accepted.

FOR OFFICE USE ONLY.

Allowed/not allowed

Rs.....

Receipt No.....

HEAD OF CONTACT LENS DEPTT

Date

[Handwritten Signature]
[Handwritten Date: 28-6-24]