Government of India

FAMILY WELFARE TRAINING & RESEARCH CENTRE

**For Identity Card** (Write in Block Letters)

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF THE COURSE:

**DIPLOMA IN HEALTH PROMOTION EDUCATION**

**POST GRADUATE DIPLOMA IN COMMUNITY HEALTH CARE**

TELEPHONE NO. (MOBILE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BLOOD GROUP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF ACCIDENT INFORM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VALIDITY:

PHOTOGRAPHS

TWO 0.75 STAMP SIZE :

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 SIGNATURE OF STUDENT