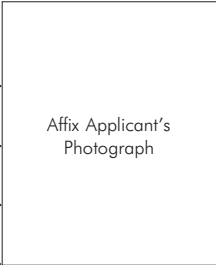




EDUCATION DIVISION
INDIAN COUNCIL OF AGRICULTURAL RESEARCH
 Krishi Anusandhan Bhavan-II, Pusa Campus, New Delhi 110 012, India

APPLICATION FORM



Affix Applicant's
Photograph

Course Name

Institute

1. Name in full (in Block letters)
2. Present Post held
3. Address for correspondence

Telephone No.

Fax No.

4. Address for contact

In case of emergency

Telephone No.

Fax No.

5. Date of birth

Nationality

Gender

Marital status

6. Educational qualifications (Bachelors degree onwards)
7. Work experience (in reverse order-starting with the present employment)
8. Proficiency in English (*Please evaluate yourself by writing 'excellent', 'good' or 'fair'*)

Reading

Writing

Speaking

9. Name of the sponsoring agency
10. Whether sponsored for any other training programme in India in the past

Yes/No

If yes, full details thereof:

11. Utility of the training in your work



- 12. Financial arrangements
- I will pay all expenses myself
- 13. Details of course registration fee remittance
- 14. Insurance

I understand that the organizers do not accept any responsibility for risks such as loss of life, accidents, illness, loss of property, theft, etc.

Date Signature of the candidate

Statement by the Employer

- (a) I the undersigned, being authorized to supply the following particulars, herewith certify that Mr./Miss/Mrs..... is employed by my organization and has been nominated to attend the course.
- (b) I consider the training to be important for the applicant's work and our organization because of the following reasons:

Signature and official stamp

Date

Name of person signing

Position

Name of Organization

Medical Record

Name

Age.....Sex.....Height.....Weight

- (i) In case having history of illness or other disorders during the last five years, please describe treatment given and present condition of health
- (ii) List any abnormalities indicated in the chest x-ray
- (iii) What is the fellow's normal blood pressure
- (iv) Is the fellow free from infectious disease (AIDS, tuberculosis, trachoma, skin disease, etc.)
- (v) Is the fellow physically and mentally able to carry on intensive training away from his/her home (Yes/No)
- (vi) Describe the fellow's overall health condition (including remarks of the examining physician)

Name and address of clinic

Name of Physician

Date

Note: This certificate may be provided by any registered medical practioner.