



St. Lords Educational Trust (R)

SHREE BHAVANI GROUP OF INSTITUTES

Recognised By Govt. of Karnataka, Indian Nursing Council, New Delhi &
Karnataka Nursing Council, Bangalore

HEAD OFFICE : Near Radhakrishna High School, Gutte Srinagar, Bangalore - 50.

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Sl. No.

Date.....

COURSES : GNM / B.Sc. (N) / PBSC (N) / MSC (N)

SCHOOL / COLLEGE

1. Name of the Candidate
(in block letters)

2. a) Name of the Father / Guardian
b) Occupation of Parent / Guardian
c) Annual income of the Parent / Guardian

3. Date of Birth and Age

4. a) Sex Male / Female
b) Marital Status

5. Whether the candidate belongs to
Karnataka/Non-Karnataka (Mention the State)

6. a) Nationality, Religion
b) Whether the candidate belongs to
(Certificate should be enclosed)

i) S.C./ S.T.
ii) Physically Challenged
iii) General

7. Mother Tongue

8. a) Highest Examination Passed

i) Reg. No.....
ii) Month & Year.....
iii) Marks.....
iv) Percentage.....

9. Address

Permanent Address

Correspondence Address

DECLARATION

I declare that above statements are true & correct to the best of my knowledge. I further certify that I have obtained permission from my parents to accept a seat in your institution, if it is offered to me. I agree to abide by the rules & regulations of the institution & Hostel.

.....
Signature of Parents / Guardian

.....
Signature of Candidate

Place :

Date :

IMPORTANT INSTRUCTIONS

List of Documents to be Attached :

- 1) A copy of S.S.L.C./Matriculation/P.U.C./P.D.C./any other educational certificate
- 2) Aadhar Card / Residential Certificate
- 3) PAN Card and Parents Income Certificate
- 4) Ten copies of recent Passport size photograph

FITNESS CERTIFICATE

(to be certified by a recognised Medical practitioner)

Height : Weight : Sight : Hearing :
Condition of : Heart : Lungs : Teeth :

Whether the candidate has suffered from any other :

Remarks :

I certify that Mr./Ms.....
and that I cannot identify any disease, constitutional weakness or bodily infirmity in him or her. I consider him/her fit to undergo training in admitted Nursing Course.

Date :

.....
Signature of Medical Practitioner

Place :

(with Seal & Reg. No.)

OFFICE USE ONLY

Admission No..... Nursing Course

Admn. Fee year.....

Date of Admission.....

Date :

Authorised Signatory