
# KARTHIK ULTRASOUND SCAN CENTRE

## ULTRASOUND SKILL TRANSFER ( TRAINING ) PROGRAM

207, 6TH CROSS, MICO LAYOUT II STAGE, AREKERE, BANNERGHATTA ROAD, BANGALORE 56 0076
EMAIL: chitra.ganesh@yahoo.co.in . WEBSITE : www.karthikultrasound.com Ph: 9844125084

## BASIC OBGYN ULTRASOUND COURSE - 4 WEEKS

1. Name :

2. Permanent Address :

   Street :

   Area :

   City :

   Zip-code :

   State :

   Country :

   Phone No :

   **Residence** STD / ISD _____ Tel _____

   **Hospital** STD / ISD _____ Tel _____

   Mobile No _____ Email _____

3. Date of Birth : ____DD ____ MM ____ YY

4. Sex : Female _____ Male _____

5. Nationality: Indian _____; if others specify _____

6. AADHAAR No : _____

6. Academic Qualification:

| Degree | Name of Degree | Name of Institution | Name of University | Date of Completion of the Course. Month & Year of passing | Class or % of Marks |
|---|---|---|---|---|---|
| **U.G.** | | | | | |
| **PG Diploma** | | | | | |
| **PG Degree** | | | | | |
| **Higher Specialty** | | | | | |

7. Academic Distinction / Publication etc:

8. Medical Council Registration Certificate – To enclose copy:

9. Present Occupation / Address:

Telephone / Mobile No.:

Email ID:

Whether in service/Private Practice:

10. Previous ultrasound experience if any:

11. Preferred month for training:

12. Objective of Joining the Course:

13. Name 2 referees in your field of profession (their contact nos. & addresses)

    1.

    2.

Note: The candidates are requested to send the following along with the application form.

1. Xerox copies of certificates
2. One passport size photo (to be affixed in the front page)
3. DD for Rs.500/- (as application fee)
4. Copy of AADHAAR

(Your registration will be completed only after the receipt of the above)

**For Office use only**

| **Payment Details** | **R. No** | **Date** | **DD. No & Amount** |
|---|---|---|---|
| **Application Fee** | | | |
| **Advance Fee** | | | |
| **Balance Fee** | | | |
| **Name of the course applied for** | | | |