NATIONAL COUNCIL FOR SKILL AND PARA MEDICAL SCIENCE

Empowering Skills • Advancing Healthcare • Building Careers

FRANCHISE ENROLLMENT APPLICATION FORM

1. Applicant Details

Name of Applicant (Proprietor / Director): _____

Father's / Guardian's Name: _____

Date of Birth: _____ Aadhar No: _____

PAN No: _____ Last Qualification: _____

2. Organization Details

Name of Organization / Institute: _____

Registration Type: ☐ Proprietorship ☐ Partnership ☐ Private Limited ☐ Trust ☐ Society ☐ Others: __

Registration No: _____

3. Institute Address

Address: At / Village / Ward No: _____

PO: _____ PS: _____ PS: _____

City: _____ State: _____ Pin Code: _____

Landmark: _____

4. Contact Details

Mobile No.: _____ Alternate Mobile No.: _____

Email ID: _____

Website (if any): _____

6. Declaration

I hereby declare that the information provided above is true and correct to the best of my knowledge. I agree to follow all rules and regulations of the **National Council for Skill and Para Medical Science** and abide by the policies of the organization.

Date: _____ Place: _____ Signature of Applicant _____

Office Use Only

Franchise Code: _____ Approval Date: _____

Authorized Signatory: _____