

# CHOITHRAM COLLEGE OF NURSING, INDORE (M.P.)



## APPLICATION FORM

### M.Sc. (Nursing)

Apex Self  
Attested  
Photo

Form No. \_\_\_\_\_

Full Name (in **BLOCK** Letters) \_\_\_\_\_

Father's/ Husband's Name & Occupation \_\_\_\_\_

Category (ST/SC/OBC) & Caste: \_\_\_\_\_

Full Permanent Address \_\_\_\_\_

Present Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Contact No. \_\_\_\_\_

E-mail(If Any) \_\_\_\_\_ Family Annual Income \_\_\_\_\_

Date of Birth and Place \_\_\_\_\_

Nursing Registration Council \_\_\_\_\_ Registration No.: \_\_\_\_\_

Give Below particulars of all academic and other examinations passed and Degree/Diploma

Examination	Year of Passing	School/College	University Board	Max. Mks/ Mks. Obt.	Academic/Dist. Scholarship	Awards
10th (High School)						
12th (Higher Sec.)						
B.Sc.(N)/ P.C.B.Sc.						

Work Experience:

Institute/Organisation	Designation	Joining Date	Field/Area	Mode of Relieving	Remarks

**Specialty Preferred: I. II. III Choice**.....

**I. Obstetric Nursing (Midwifery)    II. Psychiatric Nursing    III. Community Health Nursing    IV. Paediatric Nursing    V. Medical Surgical Nursing**

Give the Name, Profession and present address (in full) of a responsible person known to you to whom reference could be made \_\_\_\_\_

**Declaration to be signed by candidate and parents/ guardian**

I read all the rules and regulation. I hereby declare that the entries in this form are true to the best of my knowledge and belief." If I get selected I will obey all the college and hostel rules and regulations.

**Signature of Applicant**

**Name & Signature of Father/Guardian**

**Note:**

**If some one willfully suppresses any information, he/she will incur the risk of losing selection and if selected, will lose all claims to remain selected for the training.**

**Enclosures:**

***Please attach attested copies of the certificates and testimonials. Bring original documents at the time of interview.***

- A.** High School & Higher Secondary Mark sheets **B.** 3 Photographs passport size **C.** Income Certificate **D.** Medical Certificate by CMO
- E.** Permanent caste certificate by SDM & Domicile Certificate (if you are in SC/ST/OBC category) **F. Attach a DD of Rs. 1000/- in favour of 'Choithram College of Nursing', payable at Indore.** **H.** Nursing Council Registration Certificate **G.** Migration Certificate. **H.** Address Proof (Voter ID/PAN Card/ Aadhar Card)

**Fill and Send to the address below**

**Choithram College of Nursing**

Choithram Hospital & Research Centre  
Manik Bagh Road, Indore (M.P.) - 452014  
PH: 0731-2362491 – 99 (Ext.407),

**Email:** cconursing@yahoo.co.in **Website:** www.cconursing.com

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**Office Use**

Form Received Date.....Received By.....

DD No.....Amt.....Date.....

DD Sent to A/c Dept. Date.....Call Letter Sent on.....by Post/Email.....

Remarks.....

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# CHOITHRAM COLLEGE OF NURSING

CHOITHRAM HOSPITAL & RESEARCH CENTRE

MANIK BAGH ROAD, INDORE (M.P.)

## MEDICAL CERTIFICATE

### Candidate Statement & Declaration

The candidate must make the statement required below prior to his/her Medical Examination and must sign the declaration appended there to his/her attention be especially drawn to the warning contained in the note below:

State your name in full (in BLOCK letters) \_\_\_\_\_

State your date of birth and birth place \_\_\_\_\_

Have you had chicken pox, intermittent or any other fever, enlargement or suppuration of glands, spitting of blood, asthma, or Heart disease, Lung disease, fainting attack, rheumatism appendicitis?

Or

Any other disease or accident requiring confinement to bed and medical or surgical treatment?

When were you last vaccinated for -

Chicken Pox \_\_\_\_\_ Hepatitis B \_\_\_\_\_

Have you suffered from any form of nervousness due to over work or any other cause.

Are you Married/Unmarried/ Widower \_\_\_\_\_

Furnish the following particulars concerning your family -

Father's age, if living and state of health	Father's age, at death & cause of death	Mother's age, if living and state of health	Mother's age, at death & cause of death	No. of brothers and sisters living, their age & state of health

**Signature of Candidate**

**Signature in presence of**

**Seal & Signature of Medial Officer**

**Reg. No.**

**Note:**

1. If you have not had chickenpox, you should get vaccinated for the same.
2. The candidate will be responsible for the accuracy or the above statement,

# CHOITHRAM COLLEGE OF NURSING

## CHOITHRAM HOSPITAL & RESEARCH CENTRE

MANIK BAGH ROAD, INDORE (M.P.)

### FORM FOR REPORTING THE FINDINGS OF THE MEDICAL OFFICER

Report on Ms./Mrs/Mr. \_\_\_\_\_

General Development: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Nutrition:: Thin \_\_\_\_\_ Average \_\_\_\_\_ Obese \_\_\_\_\_

Height (Without Shoes) \_\_\_\_\_ Weight \_\_\_\_\_

Any Recent Change in Weight \_\_\_\_\_

Girth of Chest On full inspiration \_\_\_\_\_

On full expiration \_\_\_\_\_

Skin(Any obvious disease) \_\_\_\_\_

Eyes (Any disease) \_\_\_\_\_

Night blindness \_\_\_\_\_ Defect in colour vision \_\_\_\_\_ Visual Acuity \_\_\_\_\_

Acuity/of vision

Naked Eye With

Strength of Glasses

Glasses

Spl.

Cyl.

Axis.

Distant Vision R.E.

L.E.

Near Vision R.E.

L.E.

Ears: Inspector \_\_\_\_\_ Hearing Rt. Ear \_\_\_\_\_ Lt. Ear \_\_\_\_\_

Gland: \_\_\_\_\_

Conditions of teeth \_\_\_\_\_

Respiratory system: Does physical examination reveal anything abnormal in the respiratory organs \_\_\_\_\_

If any, explain fully: \_\_\_\_\_

Circulatory System \_\_\_\_\_

Heart, any organic lesion \_\_\_\_\_

Blood pressure, Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_

Abdomen: Hernia \_\_\_\_\_ Palpalate Liver \_\_\_\_\_ Spleen \_\_\_\_\_

Kidneys \_\_\_\_\_ Tumors \_\_\_\_\_

Nervous system, Indication of nervous or mental disabilities: \_\_\_\_\_

Locomoter system: any abnormality \_\_\_\_\_

Genito-urinary system: any evidence of hydrocele/vericoele etc. \_\_\_\_\_

Is the Candidate:- Fit \_\_\_\_\_ Unfit on account of \_\_\_\_\_

Temporarily unfit on account of : \_\_\_\_\_

**Note: There is no Classification like "Temporary Fit"**

Signature & Seal of Medical Officer

Reg. No.