INFORMATION TO BE PROVIDED FOR ISSUING NEW MEDICAL I-CARD

Name: ____

Affix one Stamp size digital photograph with good resolution

Scholar ID:____

Department: ____

Designation: ____

Date of Birth: _______________________________________

Blood Group: ____

Address: ____

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____

Contact No.: __________________________________

Put your Signature in Black Ink in the box provided above.

Information will be verified and supporting documents to be produced if asked for.