Please attach one recent photograph

SINDH MEDICAL COLLEGE
ALUMNI REGISTRATION FORM

Personal Information		
Title: Dr ☐Assistant./Associate/ Prof ☐		CNIC No:
NAME:		
S/W/D/O:		
Work Address: Affiliation/Institution/Private Practice/Others		
Date of birth (dd/mm/yyyy):		Gender: ☐ Female ☐ Male
Postal Address:		
Tel:	Mobile:	Residence:
Email:		
Year of Admission in MBBS Sindh Medical College:		
Year of Passing Final Year MBBS from Sindh Medical College:		

Post Graduate Qualification (s) [if applicable]		
Year completed	Degree (Main subject area) (e.g. MPhil Biochemistry)	University/Institution
Other Qualifications (Training/Professional Courses/Certifications) [if any may enclose]		
Year completed	Course/Training/certification (Main subject area)	University/Institution

Please attach following documents:

1. ***Final year Marks sheet (mandatory)***
2. ***CNIC copy***
3. ***One photograph***
4. ***Degree (optional)***

Date: ………………….. ***Signature:………………………***

Note: This form should be submitted in the office of Principal, Sindh Medical College, JSMU (By hand or through courier)

For office use only

Name of receiving person ___________________ date ____________________

Registration No. _______________ Page no. Of the Register ________________