

FORM - A

NATIONAL ASSOCIATION FOR REPRODUCTIVE AND CHILD HEALTH OF India (NARCHI)



Dr. C.S. DAWN, INDIAN COLLEGE OF MATERNAL & CHILD HEALTH (ICMCH)

25B, C.I.T. ROAD , ENTALLY, KOLKATA - 700014, West Bengal
Phone: 91-33-2249 5767/ 0-974877 5767 Fax: 91-33-2249 5767
Email: narchihq@gmail.com Website : www.narchi.org

Life Membership Application Form

Fix your
photo here

To,
The Secretary General, NARCHI
25B, C. I. T. Road, Kolkata - 700 014

Sir,

I am applying for life membership of **NATIONAL ASSOCIATION FOR REPRODUCTIVE AND CHILD HEALTH OF INDIA**.
I am remitting Demand Draft/ CBS cheque for Rs. 1000/- in the name of NARCHI for the membership; for DD -
payable at 'Kolkata'.

Optional: I am also sending Rs. 1000/- D/D or CBS cheque for DAWN BOOKS for all New books written by C. S.
DAWN for my standard practice.

NAME (in Block Letters) :

ADDRESS (in Block Letters) :

City / Town :

Pin Code (Compulsory):

State / Province :

Phone/ Cell Phone :

Email:

(without valid email form is not acceptable)

Date of Birth:

EDUCATIONAL QUALIFICATION

MBBS

Year

D.G.O.

Year

M.D. (Obs / Gyn)

Year

Paediatrics MD/DCH

Year

M.S. Surgery

Year

Others

Year

QUALIFICATION for non - physician Profession

PRESENT APPOINTMENT

Teaching Experience (Year)

Signature _____

Payment Type:

Cheque No.

Bank & Branch :

Demand Draft No.

Bank name

Cash


Write your name & Mobile No. back of your DD / Cheque.

Future communication from HQ will be through email and SMS ; this is part of green initiative.

Members will be responsible for intimating this office about any relevant change in the future

FORM - B

This **IDENTITY CARD** is for **DRCH & CRCH** candidates. This **FORM - B** to be filled up properly and get signed by **Fellow Guide** and to be sent to **NARCHI - HQ** along with the Admission form.

Fix your stamp size photo	NATIONAL ASSOCIATION FOR REPRODUCTIVE AND CHILD HEALTH OF India (NARCHI)	
	& Dr. C.S. DAWN, INDIAN COLLEGE OF MATERNAL & CHILD HEALTH (ICMCH)	
	25B, C.I.T. ROAD , ENTALLY, KOLKATA - 700014, West Bengal	
IDENTITY CARD		
NAME OF THE STUDENT : _____		
ROLL NO. _____		
YEAR OF ADMISSION _____ CYCLE- I : JUNE / CYCLE -II : DEC		
ADDRESS : _____ _____		
PIN CODE _____ MOBILE : _____		
NAME OF THE TRAINING HOSPITAL : _____		

NAME OF THE PROGRAMME : _____	
SIGNATURE AND SEAL OF FELLOW GUIDE	SIGNATURE OF STUDENT
DATE :	
DEAN DR C S DAWN ICMCH	SECRETARY GENERAL NARCHI - ICMCH
IDENTITY CARD IS NOT TRANSFERABLE	
It is valid only when the identity card of the student is duly attested by the Secretary General, NARCHI - ICMCH, Kolkata.	
The address, contact nos and email id cannot be changed during the course period	

FORM - D



NATIONAL ASSOCIATION FOR REPRODUCTIVE AND CHILD HEALTH OF India (NARCHI)

Dr. C.S. DAWN, INDIAN COLLEGE OF MATERNAL & CHILD HEALTH (ICMCH)

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Email: narchihq@gmail.com Website : www.narchi.org

Application for CRCH Admission

ONE YEAR COURSE FOR BAMS

Fix your
Passport
Size
photo here

To
The Dean
Dr. C. S. DAWN Indian College of Maternal & Child Health (ICMCH)
Kolkata - 700014

Respected Sir,

I am applying for admission into Residency Training for CRCH course of ICMCH - NARCHI.

Name: Dr. _____
Date of Birth _____ Sex: Male / Female _____
BAMS passed in Year _____ Date of completion of internship (compulsory): _____
Name of the Medical College (passed out): _____
Name of the University: _____
Medical Council Registration No.: _____ Date/Month/Year _____
Any prior training: From _____ to _____ Name of the Hospital / Institution
of training: _____ (Produce certificate of
training from the centre and enclose it with this application).
Date of joining the course _____

I shall abide by rules and requirements of training as per Prospectus/Guidelines and will work as Assistant to the ICMCH Fellow Guide for full period. For absence I will take leave from the Fellow Guide in writing. Course will be cancelled in case of leave without permission or any indiscipline. I understand the current status of training course - CRCH or as applicable in respect of MCI. I hereby confirm that I will not hold my Fellow Guide or College (ICMCH) responsible for any dispute arising out of this issue.

TRAINEE'S BIODATA:

Name of Trainee (in Block Letters): _____
Father's/Husband's Name: _____
Address in Block Letters: _____

City/Town: _____ Tahsil _____ Dist: _____
State _____ Pin Code _____
Telephone: STD Code _____ Phone No _____
Mobile _____ Email: _____

Date: _____

Signature of the Trainee

FELLOW GUIDE UNDERTAKING:

I agree to train the trainee for TWELVE months or more as per Prospectus/
Guidelines.

I accept Dr. _____
For training and teaching of CRCH Course from _____ to _____

Date: _____

signature of Fellow Guide

Name of Fellow Guide _____

Mobile _____ Email: _____

Name & Address of Hospital / Nursing Home / Institution of Fellow Guide (in Block letters)

Pin Code _____

Telephone with STD Code _____

Email: _____

TRAINING HOSPITAL AGREEMENT:

The Hospital agrees to give all facilities to trainee for 12 months or more working in the hospital as in the Prospectus/Guidelines.

Signature of Superintendent / CEO

Name & address of Hospital _____

(Hospital Seal)

Enclose attested Photocopies of the following (Compulsory):

1. BAMS Degree / Passing Certificate,
2. Medical Council Registration Certificate,
3. Receipts of Payments made to Fellow Guide or at Regional Centre Nagpur.
4. **Four passport size photographs, name written on the back.**

ALL SPACES IN THE FORM SHOULD BE FILLED UP APPROPRIATELY WITH RELEVANT INFORMATION AND NO BLANK SPACE OR LINE SHOULD BY LEFT