Institute of Hotel Management Catering Technology & Applied Nutrition
(an autonomous body under Department of Tourism, Govt. of Haryana)
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Affiliated to National Council for Hotel Management and Catering Technology-Noida

APPLICATION FORM FOR 1½ YEAR DIPLOMA COURSE

ACADEMIC SESSION 20____ - ____

(Select (√) Course)

- **Bakery & Confectionery** ☐
- **Food Production** ☐
- **Food and Beverage Service** ☐

Paste Recent Coloured Passport size Photograph

Name of the Candidate: ……Phno……

Father's / Husband's Name: …… Ph.No……

Mother's Name: ……Ph. No.……..

Nationality: …… Gender (M/ F):……

whether belong to SC/ BC/PH? …… (if Yes, attach certificate)

Date of birth (DD/MM/YYYY): …… Age as on 01.07.____: ……years ……. months

Permanent Address: ……..

……..

……Pin Code……

Correspondence Address: ……..

……..

……Pin Code……

Whether Haryana Domicile? ……..(if yes, attach proof)

Educational qualification

Name of the Examination	School / College	Board / University	Year of passing	Total marks	Marks obtained	% age
Matriculation						
Senior Secondary (10+2) or equivalent						
Other						
Attach self-attested copies of certificates						

Declaration: We hereby declare that particulars furnished above are true and correct to the best of our knowledge. We have carefully gone through, and understood the conditions of admission written in the information brochure.

Signature of Parent

Place ————————--

Date ————————-

Signature of Applicant

Place ————————-

Date ————————-

FOR OFFICE USE ONLY

Received by : POST/BYHAND

Date of Receipt……..

Reg.No. Assigned……

Received By ……..

Payment Details (Course Fee):

BANK …….. DD/Challan No …… Amount…….. Date ……

Receipt No:…… Date……

Accountant

Admission Approved / **Admission Cancelled**

Principal

INSTITUTE OF HOTEL MANAGEMENT CATERING TECHNOLOGY & APPLIED NUTRITION
TILYAR LAKE, ROHTAK-124001

MEDICAL CERTIFICATE

To be filled by the candidate's Medical Practitioner

Name of the candidate _____

Son/Daughter of _____

Blood Group with RH factor _____

Identification Mark _____

Address _____

_____

_____

MEDICAL HISTORY

Certified that I have examined Mr / Ms _____ whose signature is given below, in regard to following infectious diseases:

a) Skin disease _____

b) Psoriasis follicle c) _____

Tuberculosis _____

d) Trachoma _____

e) Venereal disease f) _____

Epilepsy _____

g) Leukaemia _____

Finding _____

_____

Signature of the candidate

Medical Practitioner _____

Date _____

Place _____

_____