KARNATKA STATE DENTAL COUNCIL, BANGALORE

APPLICATION FORM FOR PROVISIONAL REGISTRATION

To, SL. No.

The Registrar,
Karnataka State Dental Council,
No.23, Appajappa Agrahara,
1st Main Road, Chamarajpet,
Bangalore-560018.

Sir,

I request that my name may be provisionally registered in the Karnataka State Dental Council, Bangalore and a Certificate be issued under the Dentists Act 1948. The fee of Rs.....................is remitted through Bank. DD No......................... and Date.......................... Name of the Bank...

PARTICULARS

1. Name in Block letters:
2. Sex: Male / Female.
3. Father's Name:
4. Nationality:
5. Address-Provisional:
6. Date of Birth & Place of Birth:
7. (a)Qualification:
   (b)Date of Passing:
   (c) Register No.(B.D.S.)
8. Name of College & University:
9. Institution of Internship:
10. Date of Commencement of Internship;
11. Date of completion of Internship:

Station: Signature of Applicant
Date:

Certificate by the Head of the Institution

Certified that Dr..has passed the B.D.S. Examination held in the month of ....20.....from ....University with Register No. ....He / She will be provided with Internship training in our Institution.

Place:
Date Signature of the Head of the Institution with Office Seal