INSTITUTE OF ALLIED HEALTH SCIENCES,
RAWALPINDI MEDICAL UNIVERSITY, RAWALPINDI.

Five Year Programme	
Doctor of Physical Therapy (DPT)	

FOR OFFICE USE ONLY

Registration No_____
Application No _____
Session_____

Name of Applicant: _____

CNIC No: | | | | | | - | | | | | | | | - | |

Father's Name: _____

CNIC No: (Father) | | | | | | - | | | | | | | | - | |

Date of Birth _____

Paste One Photograph

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Unmarried

Domicile _____ Nationality: _____

Present Mailing Address: _____

_____

Permanent Address:_____

_____

Phone No: (Res) _____ Candidate Cell #_____

E-mail: _____ Father/Guardian Cell #_____

ACADEMIC QUALIFICATION

Certificate / Diploma	Institute Attended	Board / University	Grades / Marks	Passing Year
Matriculation				
F. Sc / Equivalent				
Any other Qualification				

(Please Attach Attested Photocopies of the all Supporting Documents)

We undertake that all above information are correct and liable to prosecution if found wrong.

Signature of Applicant

Signature of Father/Guardian