



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

<b>4 Year Programme (Bsc. Hons.)</b>	
Medical Imaging Technology	

<b>FOR OFFICE USE ONLY</b>
Registration No _____
Application No _____
Session _____

Name of Applicant: \_\_\_\_\_

CNIC No:      [ ][ ][ ][ ][ ][ ] - [ ][ ][ ][ ][ ][ ][ ] - [ ][ ][ ][ ][ ][ ][ ]

Father's Name: \_\_\_\_\_

CNIC No: (Father) [ ][ ][ ][ ][ ][ ] - [ ][ ][ ][ ][ ][ ][ ] - [ ][ ][ ][ ][ ][ ][ ]

Date of Birth \_\_\_\_\_

Sex:       Male     Female

Marital Status:     Married       Unmarried

Domicile \_\_\_\_\_

Nationality: \_\_\_\_\_

Paste One  
Photograph

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