CHISS - COURSE REGISTRATION FORM

CHISS
Center for Health Information Studies and Solutions

(Please complete this form in BLOCK letters)

Photograph

COURSE DETAILS					
Course Name :					
Course Start Date		Course End Date			
Method of Study	Full time ☐	Part time ☐	Evening ☐	Weekends ☐	Online ☐
PERSONAL DETAILS					
Name of the applicant					
Age	Date of birth:		Gender: Male ☐ Female ☐		
CONTACT DETAILS					
Permanent Address					
Current Address					
Home phone number					
Mobile number		Email:			
EMERGENCY CONTACT DETAILS (Please tell us who you would like the center to contact in case of emergency)					
Name					
Relation					
Address					
Mobile:		Email:			
QUALIFICATION (already obtained or expected)					
Qualification	**Institution**	**Start Date**	**End Date**	**Grade**	

WORK EXPERIENCE			
Organisation	**Position Held**	**From**	**To**
PERSONAL STATEMENT			
Why do you wish to do this course?			
Where did you find out about the courses at our Center?			

CHISS

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REFEREE 1			
Name			
Institution		Position	
Address			
Contact No. & Email			

I confirm that to the best of my knowledge, the information given in this form is correct and complete. I have read the terms and conditions and other policies of the center and agree to abide by them during my entire course of study. I agree to Center for Health Information Studies and Solutions (CHISS) processing personal data submitted in this application form, or any other data that the Center may obtain from me to the processing for any purposes connected with my studies or my health and safety, or for any other legitimate reason. I authorise CHISS to issue my course result to my sponsor if my sponsor so requests.

Applicant Signature		**Date of Application**	

Note: All decisions by the Center are taken in good faith on the basis of the statements made on your application form. If the Center discovers that you have made a false statement or have omitted significant information on your application form, for example in examination results, it may withdraw or amend its offer, or terminate your registration, according to the circumstances. The information given on this application form will be electronically stored and used for administrative purposes by the Canter.

FOR OFFICE USE ONLY

Application received Date		Student Number	
Course Applied For			
Start Date		End Date	
Offer Decision	Unconditional ☐	Conditional ☐	Reject ☐
(If conditional or Rejection please specify the condition or reason for rejection)			
Staff's Name and Signature			
Date			

Please complete the registration form along with the registration fee to :

Center for Health Information Studies and Solutions

TC 25/2850-III, Nalantha Lane,

Nanthecode, Kowdiar P.O

Thiruvananthapuram – 03

Phone No : 7511194000: Email : info@chis-solutions.com