



Sinhgad Institutes

Sinhgad Technical Education Society's  
**SINHGAD COLLEGE OF NURSING**

S. No. 49/1, Mumbai- Bangalore Westerly Bypass Highway Narhe Ambegaon (Bk) Pune - 411041.  
 Tel- 020-24106142/43 fax. 020-24699167 E-Mail- principal.scon@sinhgad.edu  
 (Approved By Indian Nursing Council, New Delhi & Maharashtra Nursing Council,  
 Mumbai, NAAC Accredited.  
 Affiliated to Maharashtra University of Health Sciences, Nashik)



**ADMISSION FORM FOR M.Sc. NURSING**  
**20 - 20**

Affix Passport size  
 Recent Photograph

\*Category: - Open/ SC/ST/VJ/NT-1/NT-2/NT-3/OBC/Other (specify):-

**1. PERSONAL INFORMATION**

(Student Sign)

	FIRST NAME	MIDDLE NAME	LAST NAME
NAME OF THE STUDENT * (AS PER 12 <sup>th</sup> MARKSHEET)			
NAME OF THE STUDENT: * देवनागरी			
FATHER'S/HUSBAND'S NAME:*			
MOTHER'S NAME:*			

*DATE OF BIRTH (DD/MM/YYYY): - / /	*MARITAL STATUS: UNMARRIED / MARRIED:-		
*PLACE OF BIRTH:-	*BLOOD GROUP ((WITH RH):-	*NATIONALITY:-	
*E- MAIL:-	*MOBILE NO-		
*ANNUAL INCOME:-			

\*ADDRESS FOR CORRESPONDENCE :- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\*PERMANENT ADDRESS:- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**2.\*LEGAL RESERVATION INFORMATION :-**

DOMICILE STATE :-	CASTE :-	SUB CASTE :-
PHYSICALLY CHALLENGED: VISUALLY IMPAIRED / SPEECH AND/OR HEARING IMPAIRED / ORTHOPEDIC DISORDER OR MENTALLY RETARDED		

**3. OTHER INFORMATION:-**

MOTHER TONGUE:-	WOULD YOU LIKE TO APPLY FOR HOSTEL: - YES/ NO
HOBBIES, PROFICIENCY AND OTHER INTERESTS:-	

**4. BANK DETAILS OF STUDENT**

1. BANK NAME - _____	6. PAN NO - <u>STUDENT</u> _____
2. BRANCH - _____	PARENT _____
3. ACCOUNT NO - _____	7. ADHAR CARD - <u>STUDENT</u> _____
4. IFSC CODE - _____	PARENT _____
5. MICR CODE - _____	

**FIRST YEAR M.SC. NURSING**

**PROFESSIONAL QUALIFICATION**

NAME OF EXAMINATION	NAME OF BOARD UNIVERSITY	DATE OF PASSING (DD/MM/YYYY)	EXAMINATION SEAT NO.(LAST)	GRADE / TOTAL MARKS OBTAINED	Remark
BASIC B. SC. / POST BASIC B. SC. NURSING					

• IS THERE ANY EDUCATIONAL GAP: - YES  NO  (IF YES ATTACH RELEVANT CERTIFICATE)

• AREA OF EXPERIENCE

CLINICAL : YEAR \_\_\_\_\_ MONTH \_\_\_\_\_  
TEACHING : YEAR \_\_\_\_\_ MONTH \_\_\_\_\_

\* PREFERENCE FOR SPECIALTY SUBJECT:-

SR. NO.	SUBJECT	SEATS	PREFERENCE NO.
01	MEDICAL SURGICAL NURSING	05	
02	PEDIATRIC NURSING	05	
03	OBSTETRIC & GYNECOLOGY NURSING	05	
04	PSYCHIATRIC NURSING	05	
05	COMMUNITY HEALTH NURSING	05	

**\*\*ATTACHED DOCUMENTS AND CERTIFICATES SECTION\*\***

SR. NO.	NAME OF DOCUMENT / CERTIFICATE	ORIGINAL	ATTESTED TRUE COPY	ATTACHED ( YES/ NO)
1	NATIONALITY / DOMICILE			
2	PASSING CERTIFICATE OF STD 10TH			
4	DEGREE / PASSING CERTIFICATE OF B.SC./P.B.B.SC. NURSING			
5	STATEMENT OF MARKS OF B.SC (ALL FOUR YEAR)./			
6	P.B.B.SC. NURSING (ALL TWO YEARS)			
7	LEAVING CERTIFICATE			
8	CERTIFICATE OF CASTE WITH CATEGORY			
9	CERTIFICATE OF CASTE VALIDITY			
10	NON CREAMY LAYER CERTIFICATE			
11	CERTIFICATE FOR PHYSICALLY CHALLENGED			
12	MEDICAL FITNESS CERTIFICATE			
13	EXPERIENCE CERTIFICATE			
14	ATTEMPT CERTIFICATE			
15	REGISTRATION CERTIFICATE ( VALID)			
16	GAP CERTIFICATE			

DECLARATION BY STUDENT:-  
I HEREBY DECLARE THAT, I HAVE READ THE RULES RELATED TO ADMISSION AND THE INFORMATION FILLED IN BY ME IN THIS FORM IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I WILL BE RESPONSIBLE FOR ANY DISCREPANCY, ARISING OUT OF THE FORM SIGNED BY ME AND I UNDERTAKE THAT, IN ABSENCE OF ANY DOCUMENT THE FINAL ADMISSION WILL NOT BE GRANTED AND/OR ADMISSION WILL STAND CANCEL.  
I AM AWARE OF THE MAHARASHTRA PROHIBITION OF RAGGING ACT, 1999 AND I STATE THAT I WILL ABIDE BY ALL THE RULES AND REGULATIONS OF THE SAID ACT.

PLACE:

DATE: -

SIGNATURE OF THE STUDENT

DECLARATION BY GUARDIAN:-

I HAVE PERMITTED MY SON/DAUGHTER/WARD TO JOIN YOUR COLLEGE. THE INFORMATION SUPPLIED BY HIM/HER IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE ACQUAINTED MYSELF WITH THE RULES AND FEES, DUES TO MY SON/DAUGHTER/WARD AND TO SEE THAT HE/SHE OBSERVES

PLACE:

DATE: -

SIGNATURE OF THE GUARDIAN

ADMINISTRATOR

PRINCIPAL

**UNDERTAKING**

IN THE EVENT OF **SINHGAD COLLEGE OF NURSING**, NARHE, PUNE.

CONSIDERING THE APPLICATION OF MR./MISS./MRS. \_\_\_\_\_

SON / DAUGHTER/WIFE OF MR. \_\_\_\_\_

RESIDING AT \_\_\_\_\_

FOR ADMISSION TO- \_\_\_\_\_ (COURSE).

I MR/MS/MRS \_\_\_\_\_

(PARENT/ LEGAL GUARDIAN) OF MR/MS/MRS \_\_\_\_\_ HEREBY AGREE TO PAY ADHOC

FEEES/FEEES PRESCRIBED BY COMPETENT AUTHORITY/ COLLEGE AUTHORITY. I HEREBY FURTHER AGREE AND UNDERTAKE THAT

IF THE FEEES( TUITION + DEVELOPMENT) AND OTHER CHARGES/ FEEES DECIDED BY SHIKSHAN SHULK SAMITI/ COMPETENT

AUTHORITY ARE MORE THAN THE ADHOC FEEES FOR THE CURRENT ACADEMIC YEAR, THEN I WILL PAY THE DIFFERENCE TO

THE INSTITUTE ON DEMAND. I SHALL ALSO PAY THE FEEES AND OTHER CHARGES DECIDED BY SHIKSHAN SHULK SAMITI/

COMPETENT AUTHORITY FOR THE SUBSEQUENT ACADEMIC YEAR.

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SIGN OF THE STUDENT.

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SIGN OF PARENT/ LEGAL GUARDIAN.

FOR COLLEGE/INSTITUTE USE ONLY:-

DESIGNATION	REMARKS / PARTICULARS/ RECOMANDATION FOR SCOLORSHIP		SIGNATURE AND DATE
ADMISSION CLERK			
ADMISSION COMMITTEE			
NAME OF THE SCHOLARSHIP	SOCIAL WELFARE	IF OTHER ( SPECIFY)	
RECOMMENDATIONS FOR SCHOLARSHIP			

REMARK: - .....

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**PRINCIPAL**

