

7th BASIC MEDICAL SCIENCES COURSE

All Disciplines/Specialties (For FCPS Part I Examinations)

Reg. No _____

REGISTRATION FORM

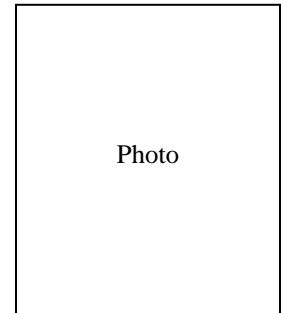
Dr. _____

F/H Name: _____ Marital Status: _____

NIC: _____ Date of Birth: _____

E-mail _____ PMDC Reg: _____

Postal Address: _____



_____ Specialty: _____

Mobile: _____ Tel. (Res): _____

Institute: _____ Tel (Off): _____

Have you attended such courses before? Yes/No, If yes please mention the

Name of course	Institutions	Year

Which Exam are you appearing FCPS _____

Please give receipt # of course fee _____ Fee date _____

Date: _____

Signature: _____

Note: Enclose the following Documents:

Receipt of Course Fee (The Course fee Rs 5,000/- is to be deposited on challan form at United Bank Limited G-8 Markaz, Islamabad or Bank draft/Pay Order in Favour of CPSP-Karachi).

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