



COLLEGE OF PHYSICIANS AND SURGEONS PAKISTAN

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REGISTRATION FORM (MCPS)

PLEASE FILL ALL COLUMNS IN CAPITAL LETTERS

NAME _____

FATHER'S/HUSBAND'S NAME _____

SUBJECT _____

ROLL NO. _____

MARITAL STATUS _____

DATE OF BIRTH _____

N.I.C. NO. _____

BANK DRAFT NO. FOR REGISTRATION FEE _____ DATE: _____

NAME OF BANK _____

PERMANENT ADDRESS _____
(Residential only)

MAILING ADDRESS _____
(Residential only)

TEL RES : _____ CLINIC : _____

HOSP : _____ FAX : _____

MOBILE : _____ E-MAIL : _____

DATE OF SUBMISSION : _____

SIGNATURE OF MEMBER _____

Staple one attested colour photograph (on the front side)
Three more attested (on the back side) photographs to be enclosed in an envelope *passport size*