



Government of Nepal
Ministry of Health
Department of Health Services
National Public Health Laboratory

PHOTO

APPLICATION FORM FOR SUPERVISED PRACTICAL TRAINING

Date :

PERSONAL INFORMATION

First Name	Middle Name	Last Name
_____	_____	_____
Age/Sex:		DOB:
Current Address:		
Permanent Address:		
Contact Number:	E-mail Address:	
Nationality:	Citizenship No.:	
Father's Name:		
Mother's Name:		

EDUCATION

Degree Awarded	University/Address	Percentage	Total Marks	Passed Year

I declare that above informations are correct

Duration of Internship

- 3 Months
 6 Months

Signature

Name:

Date:

For Official Use Only

Documents Verified By:

Name:

Post:

Signature:

Training Date: From To

Date of Submission:



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