

Application No:



Mobility India Rehabilitation Research and Training Institute

APPLICATION FORM (Academic Year: 2011-2012)

{Please complete the application and return to Academic Coordinator by 31ST March 2011

Email: academic@mobility-india.org (copy to e-mail@mobility-india.org) **Fax:** +91-80-26494444 Ext 110}

- 18 Month Lower Limb Prosthetics
- 18 Month Lower Limb Orthotics
- 36 Month Prosthetics & Orthotics
- 12 Month Rehabilitation Therapy Assistant

Affix Passport
Photos

PERSONAL DETAILS

****FILL THE APPLICATION IN BLOCK LETTERS COMPULSORILY**

Title	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Other
Sex	Male <input type="checkbox"/>		Female <input type="checkbox"/>	
Date of Birth (DD/MM/YYYY) (com				
Father Name				

Father Occupation				
Blood Group				
Mother Tongue				
Disability if applicable				
Nationality				
Permanent Address				
	Telephone Number:		Mobile Number:	
Correspondence Address				
	Telephone Number:		Mobile Number:	
Personal Email ID				
Passport Details	Number	Issued Date	Expire Date	Place
Indicate your proficiency in English	Reading	Writing	Speaking	
Rate yourself E: Excellence; G: Good; F: Fair; P: Poor				

ACADEMIC QUALIFICATION

10 TH Std		%
	Option	Percentage
Pre University (10+2)	ARTS <input type="checkbox"/> SCIENCE <input type="checkbox"/> COMMERCE <input type="checkbox"/>	%
Bachelor Degree	ARTS <input type="checkbox"/> SCIENCE <input type="checkbox"/> COMMERCE	%
Name any training/workshops undergone		
Year of experience in technical work		
Last technical course attended		

PARENT ORGANISATION DETAILS

Organisation Name		
Contact Person Name and Designation		
Address		
	Telephone No.1	
	Telephone No.2	
	Fax No	
	Mobile No	
	E-mail Id	
	Website	

FUNDER ORGANISATION DETAILS

Organisation Name		
Contact Person Name and Designation		
Address		
	Telephone No.1	
	Telephone No.2	
	Fax No	
	Mobile No	
	E-mail Id	
	Website	

To be completed by the authorities in the parent organisation (Compulsory)

This is to certify that _____ is an employee/
Non employee of our organisation for the past _____ years/selected for above said
programme.

The furnished information about the candidate is true.

Signature and seal of the official authority

Date:

Applicant Signature:

APPLICATION FORM - ADDITIONAL INFORMATION

STUDENT INFORMATION

(Note: This should be filled by candidate themselves in their own handwriting. This will be used as a valid document for evaluation of working knowledge in English).

1. Please describe your present job. (What does it involves, What responsibilities do you have)

2. What do you understand about the job you will do after you complete the training programme? (What will the work involve? How will this be different from your current job?)

3. What kinds of disabilities have you seen/worked till date?

4. Why are you interested in applying for this course?

5. If you have any disability please describe how it effects you in your day –to –day activities?
E.g. communication, eating, bathing, dressing, mobility etc.

6. If you have any disability do you use any particular aids or appliances.e.g – wheelchair, walking stick, orthosis, and prostheses. If the answer is yes, please describe.

7. Have you had any medical problem, in the past six months (If yes then please specify)

8. Are you allergic to any medicine / material / Conditions (In case yes then please specify)

9. Are you Vegetarian or Non-Vegetarian

10. Please describe your hobbies and interests

11. What do you expect to achieve during your training programme?

APPLICATION FORM - ADDITIONAL INFORMATION

To be completed by parent organisation:

Name and Designation of person completing the form _____

1. Please state why you would like the applicant to attend this particular training programme.

2. How will you support and supervise the applicant in their job following their completion of the training programme? Do you have a specific plan of action?

3. What facilities/manpower/ infrastructure do you currently have? E.g Prosthetic/ Orthotic Workshop/Unit, Therapy Unit, CBR programme.

4. Kindly mention the **approx. number of persons with disabilities** the participant has worked with **before training** and/or will be working **after training**? Please mention the type of disabilities?

Signature: _____ Date: _____

For More Information, Contact:

The Academic Coordinator
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