

APPLICATION FORM
CERTIFICATE COURSE IN
POST GRADUATE RESEARCH

Stamp size
Colour
Photograph

Paste here

1. Name in full:

2. Surname with Initials:

--

3. Date of Birth:

D	D	M	M	Y	Y	Y	Y

4. National ID number:

--	--	--	--	--	--	--	--	--	--

5. Designation:

--

6. Address (Official):

7. Address (Residence)

8. Address to which correspondence should be directed to: (Please tick \checkmark)

Official		Residence	
----------	--	-----------	--

9. Email address:

--

10. Contact telephone number:

Official:		Residence:		Mobile:	
-----------	--	------------	--	---------	--

11. Basic Qualifications

Title of Degree	Year of Registration	Duration	Field of study	Institution

12. Have you registered for a higher degree? (Please tick ✓)

Yes:		No:	
------	--	-----	--

If yes;

Title of Degree	Year of Registration	Duration	Field of study	Institution

13. Past Work Experience:

Work Station	Duration of work	Designation

Date :

.....
Applicant signature

.....
Please paste your colour photograph on above mention place in the application form and should be completed & returned **On** or **Before** the 15th of June and send by register post to Dr. Shreenika Weliange, Course Coordinator, Dept. of Community Medicine, Faculty of Medicine, Kynsey Road, Colombo 08, along with a original copy of the receipt of payment.

Please write “**Certificate Course in Post Graduate Research**” on the **Top Left Hand Corner** of the envelope.

Payment of application fees can be made to any people’s bank branch island wide. The account details are as follows

Account Number **311010400008**

Account Name –Faculty of Medicine, University of Colombo, Colombo 08

(Mention the course name and your name on the bank slip)