



SRIMANTA SANKARADEVA UNIVERSITY OF HEALTH SCIENCES

(A State University of the Govt. of Assam)

Narakasur Hilltop, Bhangagarh, Guwahati-781032, Assam

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Application form for Registration of Thesis for MD/MS Degree Course

- 1. Full Name (in block letters) :
- 2. Father's name in full :
- 3. Mother's name in full :
- 4. Present occupation and Address :
- 5. Permanent Address :
- 6. Year of passing the MBBS Examination :
- 7. University from which MBBS Exam passed :
- 8. Date of completion of Internship :
- 9. Date of joining 1st year P.G. Course :Session:
- 10. Date of completion of 1st year P.G. Course :Session:
- 11. Medical Council of India/State Medical Council (specify): Registration No:
- 12. Registration No. of Srimanta Sankaradeva University of Health Sciences:.....
- 13. Title of thesis (in block letters) :

14. Name, Designation and Academic Qualifications (in short) of the teacher under whose supervision (as Guide/ Co-Guide) he/she has proposed to do research:

- 15. Date of commencement of research :
- 16. Any Diploma course passed (Please tick “✓” on Yes or No) : Yes No
- If yes, name of the course :
- Year of Passing :
- Name of the College from which Diploma course passed :
- Name of the University from which Diploma course passed :
- Whether the Diploma course is approved/recognized by MCI :

17. Details of payment of requisite fees:

Amount of Fees paid (Rs.)	Online Receipt No. (Please enclose copy of E-Receipt)	Date of Payment

Important: The requisite fee is to be paid through online payment gateway available in SSUHS website (**Fee Collect**). A copy of E-Receipt is to be submitted along with the Application Form.

.....
Signature of the Candidate

I/we certify that Dr. is scheduled to do research for his/her thesis under my/our guidance in the subject stated in the application.
I/we recommend registration of his/her thesis work for the MD/MS Degree.

1.
Signature with Designation of Co-Supervisor (Co-Guide)

2.
Signature with Designation of Supervisor (Guide)

Countersigned

3.
Signature of the Head of the Department

Principal
.....Medical College

Sl. No.
Date of Full Registration Year.....
(To be filled in by University)