

# KARNATKA STATE DENTAL COUNCIL, BANGALORE

## APPLICATION FORM FOR PROVISIONAL REGISTRATION

To,  
The Registrar,  
Karnataka State Dental Council,  
No.23, Appajappa Agrahara,  
1st Main Road, Chamarajpet,  
Bangalore - 560018.

Sir,

I request that my name may be provisionally registered in the Karnataka State Dental Council, Bangalore and a Certificate be issued under the Dentists Act 1948. The fee of Rs.....is remitted through Bank.

DD No..... and DD Date..... Name of the Bank.....

### **PARTICULARS**

1. Name in Block letters:

2. Sex: Male / Female.

3. Father's Name:

4. Nationality:

5. Address-Provisional:

6. Date of Birth & Place of Birth:

7. (a) Qualification:

(b) Date of Passing:

(c) Register No. (BDS)

8. Name of College & University:

9. Institution of internship:

10. Date of Commencement of internship;

11. Date of completion of internship:

Station:

Date:

Signature of Applicant

### **Certificate by the Head of the institution**

Certified that Dr.....has passed the B.D.S. Examination held in the month..... of 20.....

from .....University with Register No. ....He / She will be

provided with internship training in our institution.

Place:

Date:

Signature of the Head of the institution with Office Seal