



VIJAYANAGAR INSTITUTE OF OCCUPATIONAL HEALTH AND INDUSTRIAL SAFETY

A Unit of Vijayanagar Educational Academy®

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REGISTRATION FORM VOUCHER FIRST AID TRAINING

NAME: _____

FATHER NAME: _____

DATE OF BIRTH: _____ BLOOD GROUP: _____ GENDER: _____

POSTAL ADDRESS: _____

DISTRICT: _____ PIN CODE: _____ STATE: _____

(*ATTACH PHOTOCOPY OF AADHAR CARD) AADHAR NUMBER: _____

E-MAIL ID: _____ MOB/PH.NO: _____

EMERGENCY CONTACT NO: _____

EDUCATIONAL QUALIFICATION: [*ATTACH COPY OF CERTIFICATES]:

EMPLOYMENT STATUS & COMPANY: _____

I declare that I have read and understood all the terms and conditions mentioned in the 'Guidelines' on "Voucher First aid Training "conducted by VIOHIS, Bangalore which I accept and agree.

The information furnished above are complete and true to the best of my knowledge.

Date: _____

Signature of Candidate