APPLICATION FORM

Master of Public Health (MPH)
(August-September, 2025, Session)
Department of Community Medicine,
Zoram Medical College & Hospital, Falkawn, Mizoram
Under the aegis of MIZORAM UNIVERSITY

(To be filled in by the applicant in capital letters. Please tick in the appropriate boxes)

Affix a passport size photograph here

1. **First Name:** _____ **Last Name:** _____
2. **Father's/Husband's Name:** _____
3. **Gender (Male/Female/Others):** _____
4. **Date of Birth (DD-MM-YYYY):** _____
5. **Age (*as on the last date of submission of the application*):** _____
6. **Nationality:** _____
7. **Category (SC/ST/OBC/General /PH/EWS):** _____
8. **Applicant Status (Self-Sponsored/Nominated):** _____
9. **If nominated, please give details of nominating Organization/Dept.:**

_____

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10. Academic Background:

Level of qualification	Name of the Degree	Stream / Subjects	Board/ University	College/ Institution of Affiliation	Year of passing	Aggregate Percentage
Class X	N/A	N/A				
Class XII	N/A					
Bachelors/ Undergraduate Degree						
Post graduate/ Master's or any other relevant qualification						
Any other qualification / Training						
Any other qualification / Training						

11. List of recent Academic Awards/ Achievements (If Any):

_____

_____

_____

12. Work Experience:

- **Total work experience in years:** _____

	Name of the Organization	Designation	Duration of Employment
Current			
Past			

ENCLOSURES:

i. **Transcripts of Class X and Class XII**
ii. **Degree certificates and marks sheets of Bachelor/ Under Graduate degree and any other relevant qualifications**
iii. **Latest Curriculum Vitae/ Resume**
iv. Contact details of 2 referees (academic/professional)
v. **Caste Certificate (SC/ST/OBC/PH/EWS for General Category)**
vi. **Statement of Purpose -** please see end of the form to fill in statement of purpose

****Last date for accepting applications is 01/09/2024**

APPLICANT'S ADDRESS FOR COMMUNICATION:

_____

_____

City:
State:
Country:
Pin code:
Phone (Residence):
Mobile:
Fax:
Email:

Date: **Signature:**

Please post your completed application to:
MPH Program secretariat -
Department of Community Medicine,
Zoram Medical College & Hospital, Falkawn,
Mizoram
Tel.: +91-9810703981, +91-9920473981
E-mail: mphzmc@zmc.edu.in

PLEASE WRITE STATEMENT OF PURPOSE

1) **Write in brief about you in 50-100 words.**

2) **What is your motivation for the program?**

3) **What is your academic & professional background?**

4) **Why do you wish to pursue this particular course now?**

5) **How you will use the learning of the course in future**