ZORAM MEDICAL COLLEGE

FALKAWN – 796005, MIZORAM

MBBS ADMISSION - 2024

NAME OF APPLICANT : _____

FATHER'S NAME : _____

ADDRESS : _____

_____

PHONE NO : _____

CATEGORY : ☐ AIQ ☐ STATE ☐ NRI

Form - I

ZORAM MEDICAL COLLEGE

FALKAWN, MIZORAM

Application form for admission into M.B.B.S. course for the Academic Session 2024-2025

Affix a recent Passport size colour with single colour background photograph duly signed and self-attested

(DO NOT STAPLE)

To,

The Director,
Zoram Medical College,
Falkawn, Mizoram

Through: Academic Section.

Dear Sir/Madam,

I wish to apply for the First Year MBBS course for the current academic session (2024-2025) at Zoram Medical College (ZMC). The information and documents provided by me are true to the best of my knowledge and belief. I understand that if at any stage the information submitted by me is found to be false and incomplete, my allotment is likely to be cancelled and I shall not be allowed to pursue my studies at ZMC any further.

Place: Falkawn

Date: .....

Signature of the applicant: .....

Name: .....

NEET Roll No: .....

Seat Category (State/AIQ/NRI): .....

FOR OFFICE USE ONLY

Admission Fee

Amount : _____ Payment Method : _____

Transfer No : _____ Date of Transaction : _____

Fees paid in full : Yes ☐ No ☐

Deputy Director (Accounts)
Zoram Medical College

1. Report of Medical Board : Fit ☐ Unfit ☐
2. Original Documents details : Submitted ☐ Not Submitted ☐

Academic Officer
Zoram Medical College

Dean
Zoram Medical College

Form - II

DETAILS OF THE APPLICANT

1. Personal Details

a) Full Name (in Capital) _____

b) Gender _____

c) Date of Birth (DD/MM/YYYY) _____

d) Contact No. _____

e) Email _____

f) Blood Group _____

g) Identification Mark _____

h) Religion _____

i) Community (ST/SC/OBC/Gen) _____

j) Complete Address _____

_____

_____

2. Parent Details

a) Father's Name _____

b) Contact Number _____

c) Mother's Name _____

d) Contact Number _____

3. Class 10 Standard

a) School _____

b) Board _____

c) Roll Number _____

d) Marks obtained _____ e) Full Mark _____

f) Mark Percentage _____ g) Passed year _____

4. Class 12 Standard

a) School _____

b) Board _____

c) Roll Number _____ d) PCB Total Mark _____

e) Marks obtained _____ f) Full Mark _____

g) Mark Percentage _____ h) Passed year _____

5. NEET Details

a) Roll Number _____

b) Marks obtained _____ c) Full Mark _____

d) Percentile _____ e) Rank (All India) _____

Form III

ZORAM MEDICAL COLLEGE

FALKAWN, MIZORAM

Medical Certificate

Parent/Guardian & Medical Consent

1. As parent/guardian of _____, I hereby give consent for preventative (including inoculations) and curative treatment deemed necessary by ZMC Doctors.

2. I also give consent for emergency treatment or surgery as deemed necessary by ZMC Doctors. In such a case, I understand all efforts will be made to reach me before the procedure takes place. However, in the event I cannot be reached, I give permission for the ZMC Doctors to give the necessary treatment, do the appropriate procedure, and/or refer to appropriate specialist care on my behalf.

3. I declare that all medication that my ward is taking are the medication known to the doctor and residential parent. In case of any false, incomplete or non-disclosure of information, admission to ZMC is voidable at the option of ZMC and I shall have no right, claim etc. against ZMC.

Parent's/Guardian signature : _____

Parent's/Guardian Name (in Block Letters) : _____

Date : _____

Form IV

ZORAM MEDICAL COLLEGE

FALKAWN, MIZORAM

Medical History

(To be filled in by parent / guardian)

Name of Student : _____

Date of birth : _____/_____/_____ (*dd/mm/yy)* Gender : ☐Male ☐Female

Personal medical history

Review of systems – within the last year, have you had the following (check positive answers):

General ☐ Fever ☐ Loss of appetite ☐ Weight loss ☐ Weight gain ☐ Persistent fatigue	***Skin*** ☐ Rashes / patches ☐ Lumps / Nodes ☐ Excessive / large moles ☐ Corns	***Miscellaneous*** ☐ Excessive thirst ☐ Hot or cold intolerance ☐ Night sweats ☐ Hair loss
Eyes ☐ Trouble seeing ☐ Double vision ☐ Pain	***Ears*** ☐ Ringing in ears ☐ Hearing loss ☐ Ear infections	***Nose & throat*** ☐ Nose bleeds ☐ Chronic sinus problems ☐ Recurrent Tonsillitis
Respiratory ☐ Chronic cough ☐ Shortness of breath/ wheezing ☐ Coughing up blood	***Cardiac*** ☐ Heart trouble ☐ Irregular heart beat ☐ Chest pain	***Urinary*** ☐ Frequent urination / burning urination ☐ Blood in urine
Digestive ☐ Heart burn ☐ Rectal bleeding ☐ Persistent vomiting or nausea ☐ Constipation ☐ Persistent abdominal pain ☐ Persistent diarrhoea	***Females only*** ☐ Vaginal discharge (persistent only) ☐ Irregular periods ☐ Painful menstruation (persistent only) ☐ Pelvic pain (persistent only)	***Musculo – skeletal*** ☐ Frequent joint pain or stiffness ☐ Back pain ☐ Neck pain ☐ Broken Bone ☐ Joint Injury
Neurological ☐ Dizziness ☐ Fainting ☐ Numbness ☐ Seizures	***Psychological*** ☐ Depression ☐ Mood problems ☐ Anxiety ☐ Anger Management	

Present Illness (if any):

_____

_____

_____

_____

_____

_____

Past medical history (indicate type and year): Any major illness, injury or surgery

_____

_____

_____

_____

_____

Please explain any checked answers:

Does your ward wear glasses	☐ Yes	☐No	Date of last exam
Does your ward have a hearing aid	☐ Yes	☐No	Date of last exam
Does your ward have dental problems	☐Yes	☐No	Date of last exam
Does your ward live with somebody who has tuberculosis	☐Yes	☐No	
Has your ward been exposed to anybody with AIDS/HIV/Hep B	☐Yes	☐No	

Kindly explain:

_____

_____

_____

Has your ward had *(check the appropriate box/boxes)*:

☐ Allergies	☐ Eating disorder	☐Kidney stones
☐ Anxiety disorder	☐ Epilepsy	☐Pneumonia
☐ Arthritis	☐ Fainting Spells	☐Psychosis or schizophrenia
☐ Asthma	☐ Frequent nightmares	☐Rheumatic fever
☐ Cancer	☐ Frequent urinary infections	☐Seizures
☐ Chemical dependence	☐ Headaches (recurrent)	☐Sleep walking
☐ Congenital disorder	☐ Heart disease	☐Stomach ulcer
☐ Depression	☐ Hepatitis	☐Thyroid problems
☐ Diabetes	☐ High blood pressure	
☐ Digestive problems	☐ High cholesterol	

Family history (check and indicate relationship):

☐ Allergies	☐ Chemical addiction	☐ High cholesterol
☐ Arthritis	☐ Diabetes	☐ Kidney disease
☐ Asthma	☐ Epilepsy	☐ Psychiatric (mental illness, please explain) _____
☐ Bleeding disorder	☐ Heart disease	
☐ Cancer	☐ High blood pressure	☐ Tuberculosis

Kindly explain:

_____

_____

_____

_____

Current medication:

Taking regularly : _____

Taking occasionally : _____

Allergies (note specific allergies, what the reaction was – ie penicillin-hives):

_____

_____

_____

_____

Diet (describe any dietary restrictions and indicate reason):

_____

_____

_____

_____

Describe any and all known health problems not covered above:

_____

If your ward is under any specialist care, give this person's contact details

_____

_____

_____

_____

_____

I certify the above information is true:

_____

Date:_____ Signature of parent/guardian:

Take a filled up and signed copy of this form at time of medical examination/screening prior to admission. Return duly filled in form to the ZMC Admission office. In case of any false, incomplete or non-disclosure of information, admission to ZMC is voidable at the option of ZMC and shall have no right, claim etc. against ZMC.

Form V

ZORAM MEDICAL COLLEGE

FALKAWN, MIZORAM

Physical Examination Record

This form is to be filled-in by Medical Board Member at the time of Medical Examination/Screening and returned to the student to be included with final records for ZMC:

Full Name of Student: _____ Date of birth: ____/___/___
(dd/mm/yy)

Physical examination ☐Male ☐Female

Height (cm)			Pulse	
Weight (kg)			B/P	
Visual Acuity/Eyes	R	L	Cardiovascular	
Lens Prescription	R	L	Lungs	
Hearing /Ears	R	L	Abdomen	
Skin lesions			Spine	
Lymph nodes			Extremities	
Thyroid			Neurological	
Throat				

Detail any abnormal findings: _____

Laboratory test (within 3 months prior accepted, to be done at Govt Hospital/reputed private laboratories) and reports to be produced at the time of medical examination/ screening:

Blood Group		WBC Total:		LFT:	
Blood Type		Polymorphs		Total Bilirubin	
Haemoglobin		Lymph		SGOT	
ESR (mm/hr)		EOS		SGPT	
Platelet		Mono			
		Baso			
RBS					
S. Creatine					
Chest X-Ray *(to enclose copy)*					
ECG *(to enclose copy)*					

She/he is	☐ Fit to live and work at 2,000 meters (7,000 feet) above sea level ☐ Able to participate in physical education *(Note: Physical Education (PE) is required of all students. List any restrictions, giving medical reasons)*

<table>
<tr><td>She/he has
(please give details/ symptoms of all chronic or potential problems)</td><td>☐ No known health limitations or disabilities
☐ The following health limitations/chronic problems of which ZMC should be aware of:
1.
2.
3.</td></tr>
<tr><td>She/he is taking</td><td>☐ No medication on a regular basis
☐ On the following medication:
<table><tr><th></th><th>Drug</th><th>Dose</th><th>Frequency</th><th>Duration</th></tr><tr><td>1</td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td></tr></table>All students with any chronic illness on regular medication must have a letter from their doctor with diagnosis, treatment/follow up plan and medication plan along with a prescription and sufficient medicines for the first month.</td></tr>
</table>

Recommendations:

I certify that I have reviewed the health history and examined the student and founded he/she is fit/unfit for admission of MBBS course at Zoram Medical College

Student's name: _____ Date: _____

Name of Medical Board : **Signatures of Medical Board:**

Chairman _____ _____

Member 1._____ _____

Member 2._____ _____

Member 3._____ _____

Member 4._____ _____

Form - VI

ZORAM MEDICAL COLLEGE

FALKAWN, MIZORAM

HOSTEL REQUISITION & DECLARATION FORM

I, _____

S/o. D/o. _____ here by request for accommodation in ZMC Gents/Ladies Hostel.

If granted accommodation,

1. I hereby undertake that-
   - I will abide by all the Rules and Regulations of the Hostel as set forth by the Institute.
   - I will not indulge in any behaviour or act that may come under the definition of ragging.
   - I will not participate in or abet or propagate ragging in any form. I promise to assist the authorities to curb ragging in the Institute and the Hostel.
   - I will not destroy any hostel property intentionally, and promise to pay for the replacement of any property destroyed.
   - I will not indulge in any narcotics / alcoholic activities in the hostel nor will I possess any.

2. I hereby agree that if found guilty of violation of any of the declarations mentioned above, Ifreely submit myself to any action deemed necessary by the Institution authority.

Signed this _____ day of _____ month of _____ year.

_____

Signature of Candidate

UNDERTAKING BY PARENT/GUARDIAN

I have read and accepted the declarations made by my son/daughter/ward. In case of any violation of the saiddeclarations, I will accept any action taken against my ward by the collegeauthority.

Place: Falkawn (_____)

Date: _____ *Name & Signature of parent/guardian*

Form - VII

DOCUMENT VERIFICATION & SUBMISSION FORM

This is to certify that the following documents listed below had been checked and submitted to the Academic Section from Mr/Ms _____ of NEET Roll No_____for the **MBBS Admission 2024 Batch.**The documents will remain in custody for the remainder of the MBBS course and will be returned upon completion or as permitted by the college authorities.

	List of Documents	For Doctor Duty	For Academic Section
1.	Allotment letter	☐	☐
2.	Class 10 Marksheet	☐	☐
3.	Class 10 Certificate	☐	☐
4.	Class 12 Marksheet	☐	☐
5.	Class 12 Certificate	☐	☐
6.	Transfer Certificate	☐	☐
7.	Migration Certificate	☐	☐
8.	Character Certificate	☐	☐
9.	ST / SC / OBC Certificate	☐	☐
10.	Residential Certificate	☐	☐
11.	Admit Card NEET	☐	☐
12.	Marksheet NEET	☐	☐
13.	Gap period affidavit *(if applicable)*	☐	☐
14.	PWD Certificate*(if applicable)*	☐	☐
15.	Copy of Aadhaar Card	☐	☐
16.	Medical Fitness Certificate	☐	☐
FOR NRI APPLICANT ONLY			
17.	Rate of Exchange (signed & sealed by Bank Manager)	☐	☐
18.	NRI Certificate	☐	☐
19.	Relationship Certificate	☐	☐
20.	Undertaking by Sponsor	☐	☐
21.	Embassy Certificate	☐	☐

Remarks (if any):

Place: Falkawn
Date: _____

Doctor Duty
Document Verifier
Zoram Medical College

Academic Staff
Document Receiver
Zoram Medical College