KARNATAKA STATE DENTAL COUNCIL, BANGALORE - 560 018

ಕರ್ನಾಟಕ ರಾಜ್ಯ ದಂತ ವೈದ್ಯ ಪರಿಷತ್ತು, ಬೆಂಗಳೂರು – 560 018

APPLICATION FOR REGISTRATION AS DENTIST - UNDER SECTION 34 & 35 OF DENTISTS ACT 1948

ಡೆಂಟಿಸ್ಟ್ ಆಕ್ಟ್ 1948ರ ಸೆಕ್ಷನ್ 34 ಮತ್ತು 35ರ ಅಡಿಯಲ್ಲಿ – ದಂತ ವೈದ್ಯರಾಗಿ ನೋಂದಾಯಿಸಲು ಅರ್ಜಿ

FORM-C / ನಮೂನೆ – ಸಿ

To,
The Registrar,
Karnataka State Dental Council,
No 143, 5th Main Road,
Chamarajpet, Bengaluru – 560018.

Sir,

I Request you to enter my name and address in Part-A of the Register of Dentists for the State of Karnataka.

A Registration fee of Rs…… is remitted by Bank DD/Card payment/UPI No……..

Dated…….. Name of the Bank……

Note: Fill the Application with the Block Letters Only.

1. Full Name :	
2. **Sex :**	☐ Male / ☐ Female
3. **Date of Birth and Place of Birth,**	
4. **Nationality :** (in case of Indian Nationals who are born/studied outside India, they should show proof of nationality by submission of their passports issued by the respective authorities- original and Xerox copy)	
5. **Father's Name :**	
6. **Present Address :**	
Taluk :	District :
Pin Code :	State :
7. **Permanent Address :**	
Taluk :	District :
Pin Code :	State :
8. **Category**	☐ Gen/ ☐ OBC/ ☐ SC/ ☐ ST
9. **Mobile No**	
10. **Email ID**	
11. **Aadhar Number**	
12. **PAN Card Number**	
13. **Description of Qualifications of which registration is desired**	**BDS (Bachelor of Dental Surgery)**

14. **Name of the College**	
15. **Date of Attaining the qualification (Month & Year of Final Examination)**	
16. **Name of the university which conferred the qualification**	

I hereby solemnly declare that I will follow the 'Ethical Rules for Dentists' prescribed by the Dental council of India while practicing Dentistry, a copy of which I have received.

Yours Faithfully

Place :
Date : **Signature**

CERTIFICATE BY THE HEAD OF THE INSTITUTE / COLLEGE

This is to certify that Dr.....is a bonafide student of this college and has passed B.D.S Degree examination with registration No..... in the (Month)..... year.....from this college and has completed compulsory Rotatory internship for a period of One year (Indicate Month and year of Degree) from ..... to.....and is eligible for the Degree.

Place : **Signature of the Principal Head of the Institution/College with Office Seal**

Date :

INSTRUCTIONS

1. All Particulars given above must be filled in by the applicant neatly and legibly.
2. The Names entered in the application must exactly correspond with their names entered in the university.
3. Copy of Degree Certificate or **Provisional Degree Certificate** (PDC) issued by the University with original. Permanent Degree Certificate.
4. Copy of **Compulsory Rotating Internship Completion Certificate**(CRICC) with Photo attested by principal with original.
5. Copy of **Final year part-II & Part I Marks** cards with original.
6. Original and photo copy of the **SSLC/10th Marks Sheet or Birth Certificate or Indian Passport or PAN card** to be produced which is mandatory for proof of **Date of Birth & Father Name.**
7. Two recent **Passport size Photos** with names entered on the back side of the photo (**Doctors Apron**).
8. The Total Amount payable at the time of registration by Swiping Card or UPI or through Demand Draft in the name of KARNATKA STATE DENTAL COUNCIL, BENGALURU is as follows:
   Without N.O.C Rs 2800.00/- (Including Renewal Fee)-
   With N.O.C Rs 4100.00/-

Signature of the Applicant