

**APPLICATION FORM FOR ADMISSION TO THE 6 MONTHS CERTIFICATE COURSE IN
PROFESSIONAL BARTENDING FOR THE ACADEMIC SESSION 2026 -2027**

No. _____

(Fill in Block letters)

1. Full Name: - _____

2. Date Of Birth:
(DD/MM/YYYY)

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3. Age as on 01-07-2026: - _____

4. Gender: - (Male/Female)

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5. Domicile: - _____

6. E-mail ID: - _____

7. Mobile number of the Applicant:- _____

8. Category (Gen./SC/ST/OBC, PWD/EWS-KM CERTIFICATE):-

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9. Nationality: - _____

10. Father's Name: - _____ Mobile No.: - _____

11. Mother's Name: - _____ Mobile No.: - _____

12. Permanent Address: - _____

District _____ State _____ Pin code _____

13. Correspondence Address: - _____

District _____ State _____ Pin code _____

14. Blood Group: - _____

15. Educational Qualification: (X & XII)

Sl. No.	Board/University	Stream	Marks Obtained	Division	Percentage
1					
2					

16. Name of Guardian _____ Relationship _____

**Passport
Size
Photograph**

Signature of the Student

NB: - Documents to be enclosed along with this application form.

1. Birth Certificate
2. Gen./OBC/SC/ST/PWD/EWS-KM Certificate
3. Domicile Proof
4. Marks sheets for Class X, XII
5. Provisional Certificate for XII
6. Transfer Certificate
7. Medical Report
8. 10 Passport photographs with formal dress
9. Aadhar Card

IHM CONTACT NOS. 6033415021/6033180522/6033097388/6033180520

(FORMAT FOR MEDICAL CERTIFICATE)

C E R T I F I C A T E

(To be completed and signed by a registered MBBS Doctor and presented by the candidate at the time of Admission)

Certified that I have in general and also in regard to the following infectious diseases examined Mr./Ms. _____ (Whose signature is given below) Son/Daughter of Shri./Smt. _____ Resident of _____

Disease

Finding

- a) Infectious skin diseases
- b) Psoriasis Foliate
- c) Tuberculosis
- d) Trachoma
- e) Venereal disease
- f) HIV

And find that he/she is not suffering from any of the above diseases.

I also certify that after examination I find that Mr./Ms _____ is fit to undergo the 6 Months Certificate Course in Professional Bartending.

(Signature of Candidate)

(Signature of Medical Practitioner)

Seal _____

Registration No: _____

Note : The Certificate should accompany the original Test Reports.