

Memo No- B.K.B.M./23/01

Annexure-1

Dated: 02/01/2023

NOTICE FOR ACUPUNCTURE TRAINING

Applications are invited for Certificate in Acupuncture course at Dr.B.K.Basu Memorial Research & Training Institute of Acupuncture (under Government of West Bengal) affiliated to Council of Acupuncture Therapy, West Bengal.

Eligibility: **M.B.B.S., B.H.M.S., B.A.M.S**

Duration: 16 weeks, 3 days in a week (Mon, Tue, Wed)
11 am to 4 pm.

Venue of Training: Three clinics of the institute at-

- 1) Kolkata Police Hospital,
- 2) NRS Medical College & Hospital and
- 3) Dr. B. K. Basu Memorial Research & Training Institute of Acupuncture.

Students have to attend all the clinics by rotation.

Next course will begin: **6th February 2023**

Last date of receiving application- **28th January 2023 (upto 2pm)**

Course Fee: **2500/- (Two thousand five hundred rupees only)**

Application in proforma (Annexure-2) and Self-attested photo copies of Medical qualifications (final year mark sheet), Internship completion certificate and Medical registration certificate should be sent to the **Director, Dr. B.K. Basu Memorial Research & Training Institute of Acupuncture, 188/87 Prince Anwar Shah Road, Kolkata-700045. Phone: (033) 24179281.**



Director

**Dr. B.K. Basu Memorial Research &
Training Institute of Acupuncture**

Annexure-2

APPLICATION FORM FOR ADMISSION TO CERTIFICATE IN ACUPUNCTURE COURSE

(Dr. B. K Basu Memorial Research & Training Institute of Acupuncture)

To

The Director

Dr. B. K Basu Memorial Research & Training Institute of Acupuncture

188/87, Prince Anwar Shah Road, Kol-45

Respected Sir,

With reference to your advertisement bearing memo no- BKBM/23/01, dated- 02/01/2023 for admission in **Certificate in Acupuncture** course, I want to place myself as applicant for the said training course.

(PARTICULARS TO BE FILLED UP BY THE CANDIDATE)

NAME OF THE CANDIDATE: _____
FATHER'S NAME : _____
ADDRESS : _____

DATE OF BIRTH : _____
GENDER : _____
NATIONALITY : _____
CONTACT NO (MOBILE) : _____
E-MAIL : _____

Self attested
Photo

MEDICAL QUALIFICATION:-

- a) NAME OF THE COURSE: _____
- b) NAME OF THE COLLEGE: _____
- c) NAME OF THE UNIVERSITY: _____
- d) YEAR OF PASSING: _____
- e) DATE OF COMPLETION OF INTERNSHIP: _____
- f) MEDICAL REGISTRATION NO WITH YEAR: _____
- g) NAME OF COUNCIL (STATE): _____
- h) CENTRAL COUNCIL REGISTRATION (IF ANY): _____

(ALL THE SELF ATTESTED PHOTO COPY OF RELEVANT DOCUMENTS TO BE ATTACHED)

Declaration

- i) I am declaring that the above mentioned statements and submitted documents are true. I shall be responsible for any falsification.
- ii) I declare that at present I am not engaged in any Govt. Service/ private sector (Regular/ contractual) or undergoing any academic course /training.

If any falsification detected, my candidature and registration of Acupuncture Therapy will be cancelled.

Dated:

(Full signature of Candidate)