APPL. NO. _____

VINAYAKA MISSIONS AVIATION ACADEMY

CAR 147 Approved AMT Programme
VMKV Eng. College Campus, Sankari Main Road, (NH 47), Periya Seeragapadi, Salem, Tamilnadu-636308
Mob. : 93443 35375, 93443 35376 Fax : 0427-2477903, 3012066 Website: www.vmaa.in, Email : vmaa_vinayaka@rediffmail.com

ADMISSION FORM

Paste recent Passport size colour photo with signature

(ACADEMIC YEAR 20 ____ TO 20 ___)

Mechanical Stream

Name of the Applicant (as given in 10th mark sheet) :
(FILL IN WITH BLOCK LETTERS)

Tear it from here

Date of Birth :

Mobile Number :

Email :

Father's/Guardian's Name :

Occupation :

Annual Income Rs.

Mobile Number :

Email :

Address for Correspondence:

City: _____ Dist: _____ State: _____ Pin: _____

Permanent Address:

City: _____ Dist: _____ State: _____ Pin: _____

Educational Qualification of the Applicant:

Qualification	Board / University	Year of Passing	Subjects	Total Marks	Marks Scored	% obtained	Medium

Hostel Facility Required: Yes ☐ No ☐

Declaration

I _____ hereby declare that the information given in this application form is true and correct to the best of my knowledge & belief. I have read all the rules and regulations to be followed as a student and promise to abide by them.

I further declare that I have not been admitted to any other institute; I have not been debarred from appearing at any examination conducted by any Government constituted or statutory authority.

In case of suppression of factual information or false information submitted by me, I undertake that my candidature, even after selection or during the course training, shall stand cancelled & fees will be forfeited.

_____
Applicant's Signature

_____
Father's/ Guardian's Signature

Date: _____

Place: _____

MEDICAL FORM

(To be given by Registered Medical Practitioner holding at least MBBS Degree)

MEDICAL CERTIFICATE FOR PHYSICAL FITNESS

Mr./Ms._____

(Whose signature is given below has been medically examined by me).

(a) He / She has the following

I) .....

ii) .....

iii) .....

(b) No physical disabilities.

Signature of the Applicant _____ Signature of Doctor _____

Registration No. _____

Date : _____

Tear it from here

MEDICAL CERTIFICATE FOR COLOUR VISION

I, Dr. _____ here by certify that I have examined

Mr./Ms. _____ whose signature is appended below and certify that his/her colour vision is Normal / Defective Safe / Defective Unsafe.

(Strike off whichever is not applicable)

The colour vision has been tested with :

(1) Pseudo-isochromatic plates

(2) Approved Lantern test

(3) Any other test applicable

(Strike off whichever is not applicable)

Signature of the Applicant _____ Signature of Doctor _____

Registration No. _____

Date : _____