

Eligibility

# Dr. D. Y. Patil Medical College, Hospital and Research Centre

(Re-accredited by NAAC with a CGPA of 3.62 on a four point scale at 'A' grade)

**Pimpri, Pune - 411 018** 

Contact No. 020-27805900 /100 Email:-pgsection.medical@dpu.edu.in

: Graduate in Health Science (MBBS, BAMS, BHMS, BUMS) Dentistry, Physiotherapy, Nursing, Pharmacy, B.Sc. in Bio statistics, Botany, Zoology, Public Health, Biotechnology, Dairy

### **ADVERTISEMENT**

Applications are invited for Master Degree Course in prescribed format provided on our website. The details are as follows:-

Sr.	Course	Dept.	Duration	Intake	Fees
No					
1	Master of Public Health Course	Community Medicine	2 Years	10	Rs.1,00,000/- Per Year

#### MASTER OF PUBLIC HEALTHCOURSE

	Science, Veterinary Sciences, Home Science and Health Science.
Selection Criteria	: The admission shall be done through Entrance Test and candidates should obtain 50% marks to pass the entrance test. For the admission weight age should be given as 80% for Entrance Test and 20% for marks in graduation examination of above subjects form any Indian University or their equivalent.

How to apply – interested candidate may apply with complete biodata and relevant certificates on the mail :-<u>pgsection.medical@dpu.edu.in</u> Copy to: - <u>med.psm@dpu.edu.in</u> Contact: 020-27805152, Ext: 5117 & 5126

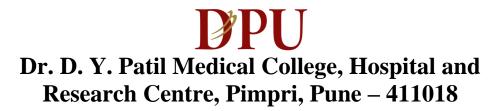
#### Sd/-(Dr. J. S. Bhawalkar) D E A N

Admission	: a) Last date of submission application is 25 <sup>th</sup> August 2019 without late fee &
Procedure	with late fee of Rs.1000/- up to 30 <sup>th</sup> August 2019.

b) Selection shall be done on inter-se merit.

c) Commencement of Course 01<sup>st</sup> September 2019.

Interested candidates should mail the application form along with scanned copies of their mark sheets, Passing certificate and Photo ID Proofs to the above mentioned e-mail address.



#### Dr. D.Y. PATIL VIDYAPEETH, PUNE

(Deemed To Be University)

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Contact No. 020-27805900 / 5100 Email:-pgsection.medical@dpu.edu.in

Application for Master Degree course in:				
Name:		_ Attach Pho		
Date of Birth:	Age:			
E-mail ID:		_		
Mobile no.: Residenti	ial no :			
Aadhar Card no:	(Attach Proof)			
Pan Card no:	(Attach Proof)			
Residential address:				
Year of Passing 10+2:		ing certificate)		
Year of Passing MBBS/BDS/any Graduation:	(Attach degree/ pass	(Attach degree/ passing certificate)		
Details of Registration with Medical Council if appli	cable: -			
- MBBS/BDS/any (Registration no. & Year)		_Attach Proof)		
Present working status: -				

Note:- Certified that the above information is correct and I am willing to work in the Department on full time basis during the period of training.

## Signature of Applicant

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