# REQUEST FOR CLINICAL TRAINING

Date

1. Name of the hospital _____
2. Address of the hospital

   _____

   _____
3. Bed strength of the hospital _____
4. Name of the Medical Superintendent _____
5. Name of the HOD Physiotherapy _____
6. NOC to be addressed in the name of _____

I have undergone through the guidelines stating objectives ,purpose and other details of the said clinical training

I undertake to abide by all rules & regulations of clinical training

I may kindly be issued NOC for the clinical training as requested above

Thanking you

Student signature

Students name _____ Enroll no._____

Res. Address _____

Email id_____

Ph no. _____