

<p>To</p> <p>The Director The Catholic Health Association of India Post Box 2126 157/6 Staff Road Gunrock Enclave SECUNDERABAD 5000 09 AP.</p>	<p>From</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
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Dear Father

I am enclosing an application of Sr.....for
 Fresh Scholarship Renewal of Scholarship [If Renewal, quote CHAI Ref No: VS- -]
from Father Victoria Memorial Scholarship Scheme of the Catholic Health Association of India
(CHAI).

If the scholarship is sanctioned, the cheque for the amount may be drawn in favour of
.....and
sent to the following address:

.....

.....

Signature of the Provincial/Regional Superior

Place.: Name:

Date: Designation:

(For office use only)

Approved the above application and sanctioned a sum of Rs

CHAI Ref.No.
VS- -

Signature of the Director
Date:



THE CATHOLIC HEALTH ASSOCIATION OF INDIA

POST BOX. 2126 GUNROCK ENCLAVE SECUNDERABAD 500 009 AP

Telephone: 040-27848293, 27848457 Fax: 040-27811982

Email directorgeneral@chai-india.org Website: www.chai-india.org

FATHER VICTORIA MEMORIAL SCHOLARSHIP SCHEME

APPLICATION FORM

[To be filled in English using BLOCK LETTERS]

PART I

[To be filled in by the candidate]

1. Name of the Candidate		
2. Date of Birth :		3. Educational Qualifications:
4. Name of the Congregation		
5. Contact address of the Candidate		6. Particulars of the Course of study
		a. Name of the Course:
		b. Duration of the Course:
		c. Current Year: <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th
Telephone:		d. Current Academic year commenced/ will commence on:
7. Name and address of the Institution, where the candidate is studying		8. Course expenditure for the current year
		a. Tuition/other Fees Rs
		b. Books/Instruments rs
		c. Hostel/Mess fees Rs
		d. Any Other Rs
Telephone:		Total Rs

9. Amount applied/received from other sources	Rs
10. Where do you intend to work after completing the course?	

I, the undersigned, hereby declare that all the above information furnished and the statements made are correct to the best of my knowledge and understanding.

Place:

Date:

Signature of the Candidate

PART II

[To be filled in by the Head of the Training Institution]

CERTIFICATE

I hereby certify that

(a) Sr..... D/o

is a bonafide student of this Institution doing her studies/training in

(b) She has successfully completed/passedSemester/year of the Course [*strike out this, if not applicable*]

(c) She is now in thesemester/year of the course.

Place:

Date :

Signature of the Head of the Institution

Name:

Designation:

(Office seal)

PART III

[To be filled in by the Provincial/Regional Superior of the Candidate]

1. Name of the Congregation	Full Name: Short Name:
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2. Name and Address of the Provincial/Regional Superior

Name:	Designation:
Address:	
Post Office:	District:
State:	Pin Code:
Mobile No.:	Telephone No.
Fax No.	Email ID:

3. Health Care Institutions owned by the Congregation

Types of Institutions	Total No. in Rural Areas	Total No. in Urban Areas
a. Health Centres (0 to 10 Beds)		
b. Hospitals (11 Beds and above)		
c. Others		

4. Has any other Sister from your Province/Region received scholarship last year? Yes No

If yes, give the particulars:

Name of the Candidate	Name of the Course	CHAI Ref No.	Amount received

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5. Has any other Sister from your Province/Region applied for/received scholarship for the current year?

Yes No

If yes, give the particulars:

Name of the Candidate	Name of the course	CHAI Ref No.	Amount received

CERTIFICATE BY THE PROVINCIAL/REGIONAL SUPERIOR

I certify that the information furnished and statements made by Sr.....
f our Congregation are true to the best of my knowledge and understanding.

In the event of CHAI granting the scholarship and if the candidate subsequently discontinues the course/training, we undertake to refund the amount to CHAI.

 Signature of the Provincial/Regional Superior

Place.:

Name:

Date:

Designation:

[Office seal]