FORM -V (See Rule 5)

FORM OF REGISTER OF TEACHERS OF APPROVED OR RECOGNISED INSTITUTIONS IMPARTING EDUCATION IN THE HOMOEOPATHIC SYSTEM OF MEDICINE

NAME OF COLLEGE: **DISTRICT:**

S. No.	No. of Registration	Date of Registration	Name	Father's Name	Date of Birth	Sex	Religion	Naitonality	Educational and Professional qualifications	Subjects taught by him	Name of Institution	Date of employment in the Institution	Emoplyed full time part time or honorary	Remarks
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