

PT. B.D. SHARMA UNIVERSITY OF HEALTH SCIENCES, ROHTAK  
FORM FOR DUPLICATE DMC / DEGREE

Demand Draft No. & Date \_\_\_\_\_ Amount: \_\_\_\_\_

1. Name : \_\_\_\_\_

2. Father's Name : \_\_\_\_\_

3. Roll No. : \_\_\_\_\_

4. Class/Semester : \_\_\_\_\_

5. Registration No. : \_\_\_\_\_

6. Reason for duplicate  
DMC/Degree mention : \_\_\_\_\_

\_\_\_\_\_

7. Correspondence  
Address & Ph. No. : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Date of Declaration of Result : \_\_\_\_\_

9. Specimen Handwriting  
of the candidate  
(please write 2-3 lines) : \_\_\_\_\_

\_\_\_\_\_

DATE : \_\_\_\_\_

SIGNATURE OF THE CANDIDATE