



**THE GUJARAT CANCER & RESEARCH INSTITUTE
NEW CIVIL HOSPITAL CAMPUS, ASARWA, AHMEDABAD-380 016**

**COMMON ENTRANCE TEST FORM FOR M.Sc. MEDICAL PHYSICS
2026-27**

CET Date: 02 JULY 2026 (Thursday)

(FILL DETAILS IN BLOCK LETTER)

FOR OFFICE USE ONLY

FOR OFFICE USE ONLY	
APPLICATION NO.	

Affix your recent
Passport size
color
Photo here (with
signature)

1. NAME OF STUDENT (AS PER MARKSHEET) : _____

2. GENDER : _____

3. MOBILE NO :

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4. PARENT'S CONTACT NO : _____

5. E-MAIL ID : _____

6. BLOOD GROUP : _____

7. NATIONALITY : _____

8. MARITAL STATUS : _____

9. RELIGION : _____

10. DATE OF BIRTH :

D	D	M	M	Y	Y	Y	Y
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11. CATEGORY(√) :

Gen		SC		ST		SEBC		EWS	
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12. ADDRESS FOR : _____

COMMUNICATION : _____

: _____

: _____ Pin code _____

13. PERMANENT ADDRESS : _____
: _____
: _____
: _____ Pin code _____

14. QUALIFICATION:

SR. No.	NAME OF EXAM	BOARD/UNIVERSITY	PASSING YEAR	PERCENTAGE	REMARK
1.					
2.					
3.					
4.					
5.					
6.					
7.					

15. DOCUMENTS SUBMITTED (Submit Relevant Document : PLEASE TICK (√))

SR. No.	NAME OF DOCUMENTS	ORIGINALS	PHOTOCOPY	REMARKS
1.	SCHOOL LEAVING CERTIFICATE / BIRTH CERTIFICATE			
2.	HIGHER SECONDARY SCHOOL MARK SHEET			
3.	HIGHER SECONDARY SCHOOL ATTEMPT CERTIFICATE			
4.	GRADUATION MARK SHEETS			
5.	GRADUATION ATTEMPT CERTIFICATE			
6.	AADHAR CARD			
7.	DISABILITY CERTIFICATE			
8.	MEDICAL FITNESS CERTIFICATE			

DECLARATION BY THE APPLICANT

I _____ son/daughter
of, _____ hereby solemnly
declare that all information furnished and enclosures given in this application are true and
complete to the best of my knowledge and belief. I am also aware that if any statement
made herein if found to be incorrect at any time either before or after CET admission, I
will be liable to forfeit my seat and / or removal from the rolls of the College at whatever
Stage of study I may be, besides making me liable for criminal prosecution.

Place:

Date:

Signature of applicant

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color
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signature)

MEDICAL FITNESS CERTIFICATE
To whom so ever it may concern

This is to certify that I have examined Mr./ Miss. _____
aged _____

He/ she is suffering / not suffering from following diseases

Asthma
Diabetes
Hypertension
Fits / Convulsions

Physical Disability
Mental Disability
Allergy

He/ she has undertaken / not undertaken all vaccination.

Any other major disease (Please specify) –

His/ Her height....., weight....., vision....., Hearing-----.

I certify that Mr. / Miss _____ is physically, mentally &
Psychologically fit / unfit for _____ course.

Marks of identification

Thumb impression

Signature & Office Seal:
Name of Registered medical practitioner:
Reg. No.:
Address:

Place:
Date: