DIRECTORATE OF TOURISM, GOVT. OF MAHARASHTRA
And
C.H.M. E SOCIETY'S BHONSALA INSTITUTE OF ADVENTURE SPORTS, NASHIK.
OPERATED
ADVENTURE SPORT TRAINING CENTRE

OFFICE NO: - 08262973554 **WEBSITE: -www.bias.bhonsala.in**

APPLICATION FORM

1. Full Name (in Capitals): _____
2. S/0, D/0, W/0: _____
3. Date of Birth: _____ Gender: _____
4. Occupation: _____Qualification: _____
5. Postal Address:

   _____

   _____

   _____Pin: _____

   Mobile: _____ Email: _____
6. Telephone with address and next of kin, Parent / Guardian:

   Name: _____

   Address: _____

   Mobile: _____ Email: _____
7. Course to be attended: _____

   Course Date From: _____ To _____

Paste passport photo

8. I have read the rules and regulations of Directorate of Tourism, Govt. of Maharashtra & C.H.M. E Society's Bhonsala Institute of Adventure Sports. Relating to the courses and have fully understood the meaning and Significance of the same. The above entries have been made by me and they are true and correct

Date: _____ Signature of Applicant _____

PAYMENTS DETAILS:

Received by NEFT / RTGS /IMPS / UPI ID NO: _____

Dated: _____ Bank Name: _____

Declarations of Guardian / Parent / Member

1. I _____ willing to admit myself/ my son / daughter / ward in Bhonsala Institute of Adventure Sports, Nashik -5, at my own risk & I will have no claims on authorities for any compensation in the event of any injury or unusual incident due to any accident during the stay/training/traveling from his / her date of joining the camp.
2. I hereby declare that I have made myself acquainted with the rules & regulations of the adventure course & I accept & agree to abide by them as long as I / my son / daughter / ward remain in the camp. I shall not hold authorities responsible for the safety of myself/ my son / ward.
3. I / my son / daughter / ward are mentally & physically fit. The Medical Fitness Certificate from a Registered Medical Practitioner is attached herewith.

Signature of Parent / Guardian: _____

Name of Parent / Guardian: _____

Relationship with student: _____

Place_____ Date_____

This application must be accompanied by [checklist]

1. Xerox copy of the Aadhar Card
2. Please bring the hard copy of form during Reporting the course.

INDEMNITY BOND AND CERTIFICATE

1) I agree to adhere strictly to the rules and discipline of the course and abide by the directions of the organizing authority or the nominee an all times during the course failing which I shall be liable for expulsion.
2) In case of any injury, accident or sickness I will not hold responsible to Directorate of Tourism, Govt. of Maharashtra & C.H.M.E Society's Bhonsala Institute of Adventure Sports or the instructors or any staff wholly or partially either individually or jointly responsible and no compensation will be claimed by me.
3) I hereby declare that to the best of my knowledge I do not suffer from any ailment or disability likely to handicap me in undergoing the course. I am taking part in this course at my own risk.
4) I also hereby declare that if my son / daughter / ward leaves camp site without authenticated permission, I will not have held responsible to any dignitary of Directorate of Tourism, Govt. of Maharashtra & C.H.M. E Society's Bhonsala Institute of Adventure Sports or the instructors or any staff wholly or partially, either individually or jointly and no compensation will be claimed by me.
5) This Indemnity bond / certificate is given by me with due diligence & on the basis of information imparted to me by Directorate of Tourism, Govt. of Maharashtra & C.H.M. E Society's Bhonsala Institute of Adventure Sports authorities.

Signature of Guardian / Parents **Signature of Applicant**

MEDICAL CERTIFICATE

(To be filled in by the family physician or Medical officer [M.B.B.S. OR M.D.])

I have medically examined Master _____ and in my opinion he is fit to undergo the Adventure Course mentioned above. He / She is not knock kneed, epileptic or flat footed and has been duly inoculated / vaccinated. He / She is allergic to _____ Height _____ cms Weight _____ Kgs. Blood Group _____

Place: _____ Date: _____

Office Seal /

Signature

Reg. No. _____

Name _____

Designation _____

HEALTH RECORD

(To be filled in by the Medical officer [M.B.B.S. OR M.D.])

CVS			**RESPIRATORY SYSTEM**		
1	Pulse Rate		3	Respiratory rate at rest	
2	Blood Pressure				
GI TRACT					
4	Abdomen		5	Eye Vision	
	a) Liver			a) Near	
	b) Spleen			b) Distant	
6	Teeth and Gums				
7	Ear, Nose & Throat				
8	Any evidence of Vertigo				