<!DOCTYPE html>

<html lang="en">

<head>

    <meta charset="UTF-8">

    <meta name="viewport" content="width=device-width, initial-scale=1.0">

    <title>Police Registration Form</title>

    <link rel="stylesheet" href="res.css">

</head>

<body>

    <div class="container">

        <h1>Student Registration Form</h1>

        <form action="#" method="post">

            <h2>Personal Information</h2>

            <label for="fullname">Full Name:</label>

            <input type="text" id="fullname" name="fullname" required>

            <label for="dob">Date of Birth:</label>

            <input type="date" id="dob" name="dob" required>

            <label for="gender">Gender:</label>

            <select id="gender" name="gender" required>

                <option value="">Select Gender</option>

                <option value="male">Male</option>

                <option value="female">Female</option>

                <option value="other">Other</option>

            </select>

            <label for="phone">Phone Number:</label>

            <input type="tel" id="phone" name="phone" pattern="[0-9]{10}" required>

            <label for="email">Email Address:</label>

            <input type="email" id="email" name="email" required>

            <h2>Address Information</h2>

            <label for="address">Current Address:</label>

            <textarea id="address" name="address" rows="4" required></textarea>

            <label for="state">State:</label>

            <input type="text" id="state" name="state" required>

            <label for="city">City:</label>

            <input type="text" id="city" name="city" required>

            <label for="pincode">Pincode:</label>

            <input type="text" id="pincode" name="pincode" pattern="[0-9]{6}" required>

            <h2>Emergency Contact</h2>

            <label for="emergency\_name">Emergency Contact Name:</label>

            <input type="text" id="emergency\_name" name="emergency\_name" required>

            <label for="emergency\_phone">Emergency Contact Number:</label>

            <input type="tel" id="emergency\_phone" name="emergency\_phone" pattern="[0-9]{10}" required>

            <input type="submit" value="Submit">

        </form>

    </div>

</body>

</html>

**CSS:**

**\* {**

**margin: 0;**

**padding: 0;**

**box-sizing: border-box;**

**font-family: Arial, sans-serif;**

**}**

**body {**

**background-color: #f4f4f4;**

**}**

**.container {**

**width: 60%;**

**margin: 50px auto;**

**background-color: #fff;**

**padding: 20px;**

**box-shadow: 0 0 10px rgba(0, 0, 0, 0.1);**

**}**

**h1 {**

**text-align: center;**

**color: #333;**

**margin-bottom: 20px;**

**}**

**form h2 {**

**margin-top: 30px;**

**color: #0056b3;**

**}**

**label {**

**font-size: 14px;**

**font-weight: bold;**

**display: block;**

**margin: 10px 0 5px;**

**}**

**input[type="text"],**

**input[type="tel"],**

**input[type="email"],**

**input[type="date"],**

**textarea,**

**select {**

**width: 100%;**

**padding: 10px;**

**margin-bottom: 20px;**

**border: 1px solid #ccc;**

**border-radius: 4px;**

**font-size: 16px;**

**}**

**input[type="submit"] {**

**width: 100%;**

**padding: 15px;**

**background-color: #0056b3;**

**color: white;**

**border: none;**

**border-radius: 4px;**

**font-size: 18px;**

**cursor: pointer;**

**}**

**input[type="submit"]:hover {**

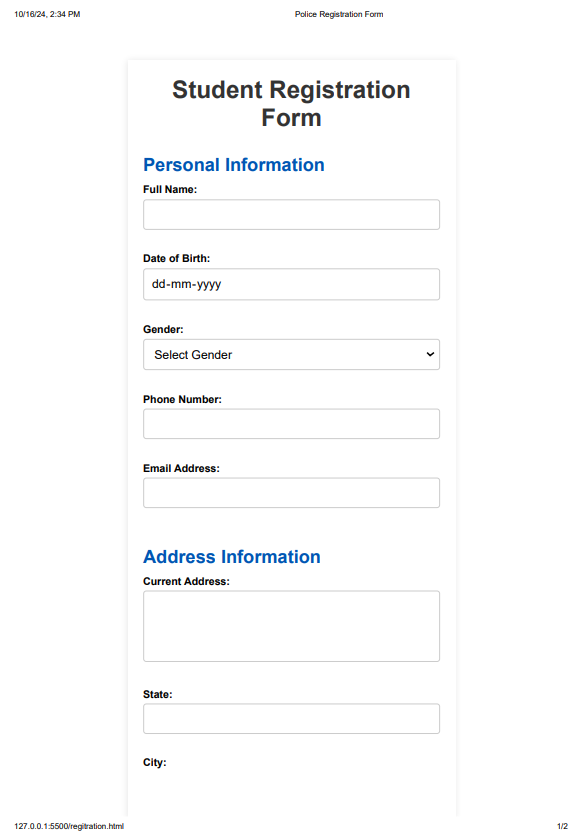
**background-color: #003d7a;**

**}**

**textarea {**

**resize: none;**

**}**

****