



**MINISTRY OF HEALTH AND FAMILY WELFARE  
GOVERNMENT OF INDIA**

Form No. 1  
Date: \_\_\_\_\_  
Place: \_\_\_\_\_  
To: \_\_\_\_\_  
From: \_\_\_\_\_  
Subject: \_\_\_\_\_

1. Name of the person: \_\_\_\_\_  
2. Age: \_\_\_\_\_  
3. Sex: \_\_\_\_\_  
4. Marital Status: \_\_\_\_\_  
5. Occupation: \_\_\_\_\_  
6. Address: \_\_\_\_\_  
7. Date of Birth: \_\_\_\_\_  
8. Date of Marriage: \_\_\_\_\_  
9. Date of Divorce: \_\_\_\_\_  
10. Date of Death: \_\_\_\_\_

Sl. No.	Name	Age	Sex	Marital Status	Occupation	Address	Date of Birth	Date of Marriage	Date of Divorce	Date of Death
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Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Place: \_\_\_\_\_  
Official Seal: \_\_\_\_\_  
Remarks: \_\_\_\_\_