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ICBio™
Excellence in Biosciences

STRATEGIC ALLIANCE PARTNER APPLICATION FORM

NAME ____ Pass port Size Photograph

DATE OF BIRTH : ______________________________

QUALIFICATIONS : _____________________________________

POSTAL ADDRESS : _____________________________________

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CITY _________________________STATE __________________ PIN _____________

TELEPHONE NOs Off:_____________________ Resi. ______________________

Mobile: _____________________ Fax : ______________________

E-mail: ____

CHOICE OF CITY FOR ICBIO CENTER: ____

YOUR PROFESSION: SERVICE BUSINESS

If BUSINESS: TYPE OF BUSINESS AND TURNOVER ___________________________________

TYPE OF FIRM : PROPRIETORSHIP PARTNERSHIP PVT. LTD.

NAME OF THE PARTNER(S) IF ANY ____

PROPOSED LOCATION WITHIN THE CITY ____

DO YOU OWN PREMISES YES NO

IF YES , SIZE IN SQ. MTS ____________ LOCATION _____________________________________

HOW SOON CAN YOU START THE PROJECT? WITHIN 2 MONTHS AFTER 2 MONTHS

NAME:
SIGNATURE
DATE:
PLACE:

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Enclose:

Please attach a report with the following details:

1. Promoters credentials : (Please attach CV of all Partners)
2. Enumeration of goals in the field of clinical research education:
3. Promoter's vision of ICBIO Learning Center in next 5 years.
4. Site photograph:
5. Details of major competition:
6. Your marketing strategy for promoting ICBIO programs and your projection of students enrollments in the first year of operation: