



CENTRE OF EXCELLENCE FORM member

Name of the Institution: _____

Name of the Representative: _____

Designation (CEO/ MD/ Chairman/ Founder): _____

Address: _____

Phone: _____ Fax: _____ Mobile: _____

Email: _____ Website: _____

Courses Available: _____

Nos of students <500 500-1000 1000+

Number of Employees: _____

Location of Campuses if more than one : _____

I/We _____ on behalf/ representative of

_____ in capacity of _____

would associate with "Entrepreneurship and Skill Development Association" as a Centre Of Excellence towards the common vision "Mission against Unemployment".

(Signature with Seal)

For Office Use Only

Registration Number: _____ Membership Number: _____

Date: _____