

अंचल कार्यालय, लखनऊ / ZONAL OFFICE LUCKNOW

ANNEXURE

Application for PART TIME MEDICAL CONSULTANT

PLEASE AFFIX  
PHOTOGRAPH HERE

(ALL IN CAPITAL)

1. NAME : \_\_\_\_\_  
(Surname) (Name) (Middle Name)

2. FATHER'S NAME :

3. (a) DATE OF BIRTH :

(b) AGE IN YEAR :

4. NATIONALTY :

5. MARITAL STATUS :

6. (a) ADDRESS : \_\_\_\_\_  
(PERMANENT) \_\_\_\_\_

CITY

PIN

(b) ADDRESS : \_\_\_\_\_  
(COMMUNICATION) \_\_\_\_\_

CITY

PIN

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7. CONTACT DETAILS : \_\_\_\_\_

RESIDENCE : \_\_\_\_\_

MOBILE : \_\_\_\_\_

EMAIL ID : \_\_\_\_\_

8. EDUCATION QUALIFICATION:

Exam Passed	Year of Passing	University / Board	Name of Institution	% age / Mark	Grade

9. EXPERIENCE:

S. No.	Name of the Organization (starting with the present employer)	From Date	To Date	Posted at	Designation

I hereby declare that the information furnished above is true.

(Attach the copy of the Education Qualification and Experience Certificate)

Date:

Place:

\_\_\_\_\_

(Signature of the candidate)

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