

APPLICATION FORM

HEALTH, MEDICAL & FAMILY WELFARE DEPARTMENT DISTRICT HEALTH & FAMILY WELFARE SOCIETY(NTEP), KURNOOL.

REGISTRATION NO.
(TO BE FILLED BY THE OFFICE)

NAME OF THE POST APPLIED::

1	Name of the Applicant (In block letters as per SSC Marks list)									
2	Name of the Father									
3	Name of the Spouse (if Married)									
4	Gender									
5	Date of Birth (As per SSC marks certificate)									
6	Age as on 31.07.2023									
7	Social Status (SC/ST/BC-A,B,C,D/ EWS Others) Latest caste certificate issued by Tahsildar to be enclosed)	OC	BC A	BC B	BC C	BC D	BC E	SC	ST	EWS
8	Status (Local/ Non Local) as per study from 4 th to 10 th class									
9	Whether belongs to Physical handicapped Specify details (VH / HH / OH) Category (Latest certificate to be enclosed by Medical Board) (SADARAN)									
10	Whether Sports if any details:									
11	Whether Ex-servicemen/women	YES/NO								
12	Name of the requisite Qualification the applicant passed (Name of the Course)									
	Date of the completion of above requisite Qualification									
	Respective Council Registration No. & Date & Up to validity									
13	Whether belongs to Economically weaker section category									

16. DETAILS OF SCHOOL EDUCATION:

SL. No.	CLASS	YEAR OF PASSING	NAME OF THE SCHOOL & PLACE	DISTRICT IN WHICH STUDIED
01	IV			
02	V			
03	VI			
04	VII			
05	VIII			
06	IX			
07	X			

Study certificates from IVth to Xth should be enclosed otherwise candidate will be treated as NON LOCAL.

17. EDUCATIONAL QUALIFICATION:**ACADEMIC MARKS OBTAINED IN THE ESSENTIAL QUALIFICATION**

S.No	Qualifying Examination	Year of passing	Total Marks	Marks Obtained	% of Marks Obtained

MARKS OBTAINED IN THE PREFERENTIAL QUALIFICATION

S.No	Qualifying Examination	Year of passing	Total Marks	Marks Obtained	% of Marks Obtained

18. EXPERIENCE IN GOVERNMENT MEDICAL INSTITUTIONS IF ANY :
(Should be submit in prescribed Proforma)

Sl. No.	Name of the Government Institution	Experience		No.of completed 06 months
		From	To	

19. ADDRESS FOR COMMUNICATION ALONG WITH MOBILE NUMBER :

Name of the Applicant	
Name of the Father	
Name of the Spouse (if Married)	
House No	
Street/Village	
Mandal/District	
Pincode	
Mobile No.	
Email ID	

DECLARATION

I Sri/Kum/Smt..... S/o (or) D/o (or) W/o
solemnly declare that the particulars given above are correct to the best of my knowledge and belief. I also agree that in the event of any of the particulars furnished in my application being found to be incorrect or false at a later date, my appointment will be cancelled summarily.

Date::

Place::

SIGNATURE OF THE APPLICANT

CERTIFICATE OF CONTRACTUAL/OUTSOURCING/COVID-19 SERVICE

(To be issued by the controlling officer concerned DM&HO /
DCHS / any other competent authority)

This is to certify that Sri. / Smt. _____

S/o D/o _____ has been working as _____

at _____ on contract /outsourcing basis. The

details of his/ her services as on 31.07.2023 are as follows:

Name of the Institution	Tribal/ Rural/ Urban	Workingperiod		Length of Services as on 31.07.2023 YY.MM.DD	No. of 06 months completed	Reasons for break in service if any	Whether there is financial concurrence for recruitment	Allegations / adverse remarks if any
		From	To					

I hereby declare that,

1. His/ her services during the contract /outsourcing /COVID period are satisfactory.
2. He /She is appointed on contract basis through DSC/ through outsourcing agency/COVID.
3. He / She does not have any adverse remarks from his / her superiors.
4. He / She is eligible weightage under contract / outsourcing/COVID as per the rules.

SIGNATURE OF CONTROLLING OFFICER
(DMHO/DCHS/ANY OTHER COMPETENT
AUTHORITY

Station:

Date: