Health Department Government of Khyber Pakhtunkhwa

APPLICATION FORM

Affix your recent passport size photograph here

Post Applied For: Medical Officer ☐ Dental Surgeon ☐ Nurse ☐

Read the following instructions carefully before filling the form.

- ***This application form, duly completed should be submitted to the office of Divisional Commissioner on or before the due date along-with the following documents: -***
- *Attested photocopies of all required degrees / certificates / domicile / Experience Certificates etc.*
- ***Incomplete application forms and those received after the due date will not be entertained.***
- ***Use additional sheets, if required.***
- ***Fill all the columns. Write N/A if not applicable***

1. Name: (in capital letters)

2. Father's Name: (in capital letters)

3. Gender: (Please Tick) ☐ **Male** ☐ **Female** **4. CNIC No.** _____-_____-_

5. Mailing Address: (for correspondence)

6. Permanent Address:

7. Mobile/Cell No 1: **8. Mobile/Cell No 2:**

9. Landline No: **10. E-Mail:**

11. Date of Birth: __-__-____ **12. Nationality:**

12. District: **13. Marital Status:**

14. Domicile: **15. PMDC/PNC Reg No.**

16. ACADEMIC QUALIFICATION: Commencing from the Matriculation or Equivalent Examination

S#	Certificate / Degree	Name of Board / University	Exam. with year of passing	Obtained / Total Marks	% Marks / CGPA
1.	Matric				
2.					
3.					
4.					
5.					

17. ADDITIONAL RELEVANT QUALIFICATION/ Professional Qualification/Training/Certification/Others, if any;

S#	Certificate/ Degree/Diploma/ Training/Workshops	Name of Board / University	Year of passing	Period		% Marks Obtained / CGPA
				From	To	
1.						
2.						
3.						
4.						

18. EMPLOYMENT RECORD: (in chronological order, starting with latest employment – use extra sheet if required)

S#	Name of Institute / Organization	Designation	BPS / Grade	Nature of Job (Permanent/ Regular/ Contractual)	Status of Organization (Govt./Semi Govt./ Autonomous/ Private	Period		Total Length of Service
						From	To	
1.								
2.								
3.								
4.								

19. Preference for optioning health facilities (priority wise)

S#	Facility Code	Priority	Name of Health Facility	District	Division
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

20. Total Experience ☐ **Years** ☐ **Months** ☐ **Days**

I hereby declare that all the entries made in this application form and the additional particulars/documents furnished therein are true and to the best of my knowledge and belief. I understand that incomplete form will be sufficient ground to reject my job application form.

Date: _____/_____/_____

_____

Signature of Applicant