

APPLICATION FORM

Please download three copies and submit the three attested copy at the time of counseling)
COMPULSORY RESIDENT SPECIALIST

Speciality: _____ **Degree/ Diploma:** _____

Area of study OU/SVU/AU : _____

Local Non Local

Affix Photo

Name of College and Place: _____

1.Name of the Candidate : _____

(Full Name in block letter including surname)

2.Reg.No. (Dr.NTR UHS) : _____

3.Email-id : _____

4.Phone / Mobile No. : _____

5.Address for communication : _____

6. Sex : Male/Female

7. Community : OC/BC/SC/ST

8. Date of Birth :

D	D	M	M	Y	Y	Y	Y

9.Father's / Husband / Wife (1) Address : _____

(2) Contact No : _____

10. Theory Marks obtained in the Diploma / Degree /Super Specialty exam : _____

11. Whether Spouse is working in Govt. service or doing PG : Yes / No

12. Details of Bank Account : _____

1) Name of the Bank : _____

2) Branch : _____

3) Account No : _____

4) IFSC code : _____

13. PAN No. : _____

Signature of Candidate

Signature of the Principal

(For office use only)

Allotted for posting from _____ to _____ in DME/APVVP/ Others ,
In _____ College / Hospital.

Signature of Counseling Authority

for Director of Medical Education