APPLICATION FORM

(Please download three copies and submit the three attested copy at the time of counseling)

COMPULSORY RESIDENT SPECIALIST – SUPER SPECIALITY – MCH/DM

Speciality: _____ MCH/DM:_____

Affix Photo

Area of study OU/SVU/AU :_____

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. Date of Birth **:** ☐☐☐☐☐☐☐☐

D D M M Y Y Y Y

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

_____

_____

(2) Contact No **:**_____

9. Theory Marks obtained in the Super Specialty exam: _____

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

11. Details of Bank Account **:**

1) Name of the Bank **:**_____

2) Branch **:**_____

3) Account No **:**_____

4) IFSC code **:**_____

12. 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