

**OFFICE OF THE COMMISSIONER AP VADIYA VIDHANA
PARISHAD::VIJAYAWADA**

Rc.No.3380/G/2018

Dated:10.05.2018

CIRCULAR

Sub: GENERAL TRANSFERS 2018 - transfer on Mutual / request - Transfer Applications - Called for - Reg.

Ref: 1.G.O.Ms.No.57 F (HR.I.PLG & POLICY) Dept dated 08.05.2018.

2.List of Vacancies in all cadres in APVVP hospitals.

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The attention of all the officers noted in the address entry is invited to the reference cited. They are directed to display the vacancies as given in the reference 2nd cited in the premises of their offices and to direct the employees in respect of all Zonal and State cadre posts to submit to this office on or before 5 pm on 15.05.2018 in the given proforma enclosed.

Further all the officers noted in the address entry are requested to ensure that the guidelines/ instructions issued by the government in the 1st reference cited are followed and to forward the applications to this office.

They are also directed to effect District Cadre transfers duly following the guidelines given vide reference 1st cited.

**Sd/- Dr.P.Durga Prasada Rao
Commissioner
APVVP**

To

All the DCHS, Medical Superintendents and Medical Officers of APVVP hospitals

Application for Transfer

1	Name of the Employee:	
2.	Designation:	
3	Place of working :	
4	Date of Joining in the Department:	
5	Date of Joining in the Present Station :	
6	Duration of stay at present station as on 1.05.2018:	Years Months days
7	GROUND'S For TRANSFER	<input type="checkbox"/> REQUEST <input type="checkbox"/> MUTUAL
8	<p>If ON MUTUAL,</p> <p>a.Place of Mutal Request</p> <p>b. Name of the employee with whom mutal transfer is requested.</p> <p>c. Duration of his/her stay in the present station.</p> <p>(Letter of willing ness of employee for mutal transfer verified and certified by controlling officer,i.e, MO/MS/DCHS to be enclosed.</p>	
9	<p>If on request , mention the conditions fulfilled for request with details as given below tick against the appropiate box</p> <p><input type="checkbox"/> a. Visually challenged persons.</p> <p><input type="checkbox"/> b.Employee with disabilities of 40% or</p>	Details

	<p>more as certified by a competent authority as per persons with disabilities.</p> <p><input type="checkbox"/> c.Husband and wife cases (only one of the spouses shall be shifted following the prescribed procedure).Once the facility is utilized,the next request can be made only after eight years.</p> <p>If so, the place of spouse working:</p> <ol style="list-style-type: none"> 1.Name and designation of spouse 2. The place of spouse working. <p><input type="checkbox"/> d.Employees having mentally retarded Children to a place where medical Facilities are available.</p> <p><input type="checkbox"/> e.Widow employee appointed on Compassionate basis.</p> <p><input type="checkbox"/> f.Medical grounds for the diseases (either self or spouse or dependent children and dependent parents) of Cancer, Open Heart Operations, Neuro surgery, Kidney Transplantation to places where such facilities available.</p>	
10	Details of Certificates/Documents Enclosed in support of the claim:	
11	Mention if any Disciplinary cases pending	

12	Places of preference if applied on request in the order of priority	1.
		2.
		3.
		4.
		5.
13	Mobile Number & Email ID	
14	Other information if any	

Signature of the Applicant

DECLARATION

I, here by declare that the particulars furnished by me are correct to the best of my knowledge and belief. I know that if any particulars are found to be incorrect on verification, I will be liable for disciplinary as well as criminal action. All the required certificates/ documents in support of above facts are enclosed.

Signature

Name of the applicant

Designation

Date

CERTIFICATE

Certified that the particulars furnished by the applicant are verified with reference to certificates/ documents/ Service Register of the individual and found correct.

Signature of the Head of the Institution

Designation with stamp

Counter Signature of DCHS