

APPLICATION FOR THE POST OF CIVIL ASSISTANT SURGEONS IN DIRECTOR OF PUBLIC HEALTH &
FAMILY WELFARE,
ANDHRA PRADESH: GOLLAPUDI :: VIJAYAWADA

Registration No.

Latest Passport
size Photo Attested
by Gazetted Officer

Registration Fee: Demand Draft for Rs. 500/- (Rupees five hundred only) in favour of Director of Public Health & Family Welfare, A.P., Gollapudi, Vijayawada Payable at Vijayawada (Fee is exempted for SC & ST candidates as per Govt. Rules)		DD Number	Date	Name of the Bank & Branch							
1	Name of the Applicant (in Capital Letters)	Sur Name			Name						
2	Father's Name										
3	Sex	Male				Female		Trans Gender			
4	Date of Birth (DD-MM-YYYY)	D	D	M	M	Y	Y	Y	Y		
5	Age as on 01-07-2018	D	D	M	M	Y	Y	Y	Y		
6	Religion										
7	Social Status	ST/SC/ BC / OC			If BC Category Specify Group :		A	B	C	D	E
8	Whether claiming relaxation of Age if any (Specify the category)										
9	Whether belongs to Physically handicapped (Certificate issued by Medical Board only are accepted. Other certificates rejected summarily)										
10	Whether belongs to Ex-Service Men category : length of service in armed force(Certificate to that effect issued by concerned authorities to be enclosed)										
11	Details of School Education (Certificates must be enclosed)										
Sl. No.	Class	Name of the School & Place			Year of Passing			District			
1	IV										
2	V										
3	VI										
4	VII										
5	VIII										
6	IX										
7	X										

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12. Details of Educational Qualification : (Attested copies to be enclosed)

Sl. No.	Educational Qualifications	Month and Year of Passing	Name of the College & University	Aggregate of marks obtained in all the years	Percentage of Marks
1	MBBS				

13. Registration details:

a.	Internship Period		
b.	A.P. Medical Council Regd. No & Date		

14	Are you working on contract with Govt. of A.P.	Yes	No
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15	If Yes : Certificate in prescribed proforma from the controlling officers concerned i.e. DM&HO/DCHS, any other recruitment authority) to be enclosed)				
16	Length of Contract Service	Years	Months	Days	

Name of the institution	From	To	Tribal / Rural / Urban

17

Address for communication along with PIN Code: (in capital letters)

Name of the Candidate ::
Fathers / Husband Name ::
House. No. ::
Street ::
Village/ Town / City ::
Mandal ::
District ::
PIN CODE ::
STATE ::
MOBILE NO. ::
e-MAIL ID

DECLARATION OF THE APPLICANT

I, Dr. _____ S/o, D/o,
W/o, _____ certify that the particulars
given above are correct and true 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 and I will be liable for
punishments if any as per rules and law.

I, Dr. _____ S/o, D/o,
W/o, _____ will abide by the rules
under which I may be appointed and regular service in any part of Andhra Pradesh if selected.
I will join in the place where I am posted as per the requirement of the department within the
stipulated time specified by the authorities failing which I forfeit my rights to be appointed in
this recruitment.

Station:

Date :

SIGNATURE OF THE APPLICANT

CERTIFICATE TO BE ISSUED BY THE CONTROLLING OFFICER CONCERNED
DM&HO / DCHS / ANY OTHER APPOINTING AUTHORITY

This is to certify that Dr. _____, S/o,
D/o _____ has been working as
_____ in PHC/CHC/AH/District Hospital on contract basis with
the financial concurrence of the Government. The details of his/her service as on
26-09-2018 are as follows:

Name of the Institution	Tribal/Rural / Urban	Working Period		Reasons for breaking service if any	Whether there is financial concurrence for recruitment	Chares / Allegations / Adverse remarks if any
		From	To			

I hereby declare that,

1. His/ her services as Medical Officer during the contract period are satisfactory.
2. He/she does not have any adverse remarks from his/ her superiors during the period of contract service as Medial Officer.
3. He / She is eligible for contractual service weightage as per the rules published in the notification and Government Orders.

Station:

Date :

SIGNATURE OF CONTROLLING OFFICER
(DM&HO / DCHS / ANY OTHER
AUTHORITY WHO APPOINTED THE
APPLICANT)

CHECK LIST

Name of the Candidate: _____

Date of Birth : _____

Enclosures of Xerox documents along with Application:

1	SSC Certificate	Yes	No
2	Latest Caste Certificate	Yes	No
3	Study/ Bonafide Certificate (Class IV to Class X)	Yes	No
4	MBBS Marks list (All years)	Yes	No
5	AP Medical Council Registration Certificate	Yes	No
6	Internship completion certificate	Yes	No
7	Latest Physically handicapped certificate (should be issued by medical board(other certificates summarily rejected)	Yes	No
8	Contract Service certificate	Yes	No
9	Residence certificate to the applicants who have not studied in school from 4 th Class to 10 th Class	Yes	No
10	Demand Draft for Rs. 500/- (Rupees five hundred only) in favour of Director of Public Health & Family Welfare, A.P., Gollapudi, Vijayawada Payable at Vijayawada (Fee is exempted for SC & ST candidates as per Govt. Rules)	Yes	No
11	Self-addressed cover of size 12X26 CM with postal stamps worth of Rs.40/- (Rupees forty only)	Yes	No
12	Self addressed Post card if application submitted by post	Yes	No

Station:

Date :

SIGNATURE OF THE APPLICANT