APPLICATION FORM

GOVERNMENT OF ANDHRA PRADESH
OFFICE OF THE SUPERINTENDENT, GOVT. REGIONAL EYE HOSPITAL, KURNOOL.

APPLICATION FOR RECRUITMENT OF PARAMEDICAL AND OTHER POSTS ON CONTRACT/OUTSOURCING BASIS TO WORK AT GGH, KURNOOLAS PER G.O.Ms.No.140&141 HM&FW Dt.17.11.2021.

REGISTRATION NO.
(TO BE FILLED BY THE OFFICE)

NAME OF THE POST APPLIED::

1	Name of the Applicant (In block letters as per SSC Marks list)									
2	Name of the Father									
3	Name of the Spouse (if Married)									
4	Gender									
5	Date of Birth (As per SSC marks certificate)									
6	Age as on 01.07.2021									
7	Social Status (**SC/ST/BC-A,B,C,D/ EWS** Others) Latest caste certificate issued by Tahsildar to be enclosed)	OC	BC A	BC B	BC C	BC D	BC E	SC	ST	EWS
8	Status (Local/ Non Local) as per study from 4th to 10th class									
9	Whether belongs to Physical handicapped Specify details (**VH / HH / OH /)** Category (Latest certificate to be enclosed by Medical Board) (SADARAN)									
10	Whether Sports if any details:									
11	Whether Ex-servicemen/women	YES/NO								
12	Name of the requisite Qualification the applicant passed (Name of the Course)									
	Date of the completion of above requisite Qualification									
	Respective Council Registration No. & Date. & Up to validity									
13	Whether belongs to Economically weaker section category									
14	Demand Draft Number, Date and Amount									

15. DETAILS OF SCHOOL EDUCATION:

SL. NO.	CLASS	YEAR OF PASSING	NAME OF THE SCHOOL & PLACE	DISTRICT IN WHICH STUDIED
01	IV			
02	V			
03	VI			
04	VII			
05	VIII			
06	IX			
07	X			

Study certificates from IVth to Xth should be enclosed otherwise candidate will be treated as NON LOCAL

16. EDUCATIONAL QUALIFICATION:

ACADEMIC MARKS OBTAINED IN THE QUALIFYING EXAMINATION

Qualifying Examination	Year of passing	Total Marks	Marks Obtained	% of Marks Obtained

TECHNICAL MARKS OBTAINED IN THE QUALIFYING EXAMINATION

Qualifying Examination	Year of passing	Total Marks	Marks Obtained	% of Marks obtained

17. EXPERIENCE IN GOVERNMENT MEDICAL INSTITUTIONS IF ANY :

Sl. No.	Name of the Government Medical Institution/ Hospital	Experience		No.of completed 6 months
		From	To	

18. ADDRESS FOR COMMUNICATION ALONG WITH MOBILE NUMBER :

Name of the Applicant	
Name of the Father	
Name of the Spouse (if Married)	
House No	
Street/Village	
Mandal/District	
Pincode	
Mobile No.	
Email ID	

DECLARATION

I Sri/Kum/Smt..... S/O (or) D/O (or) W/O .....solemnly declare that the particulars given above are correct 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.

Date::

Place:: SIGNATURE OF THE APPLICANT