

7. Experience (if any) (Attach separate sheet, if columns are insufficient)

Post held	Name of Institution	Period of service		No. of completed years & months	Scale of pay and salary per month
		From	To		

8. Are you Registered with Medical Council of India?

(Please mark (✓) tick in the appropriate box)

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Registration Number:	<input type="text"/>
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UNDERTAKING

I hereby certify that all the information given above is true and correct to the best of my knowledge. I have attached attested copies of my testimonials in support of the entries made above. I also agree that mere eligibility does not confer right to be called for interview/selection. My candidature may be cancelled in case any information is found to be incorrect on verification.

Place _____

Signature _____

Date _____

Name _____

- 1. It is compulsory to submit self-attested photo copies of all the testimonials along with this Application form.**
- 2. Candidates are requested to carry original testimonials along with them at the time of joining.**