

## APPLICATION FORM

### APPLICATION FOR THE POST OF .....ON CONTRACT BASIS(RNTCP)

Regn. No.

Application No.

(To be given by "O/o.DTBCO" of E.G. District )

|  |   |
|--|---|
| 1) Name of the applicant<br>(in BLOCK letters)   |   |
| 2) Father's Name/Husband's Name  |   |
| 3) Sex :   | 4) Date of birth :  |
| 5) Religion :  | 6) Social Status (latest Certificate) :<br>(SC/ST/BC with group/OC) |
| 7) Relaxation of age if any :  |   |
| 8) Whether belongs to physically handicapped<br>(latest Certificate issued by the Medical board only to be enclosed) |   |
| 9) If belongs to Ex-Service men, length of service in armed force<br>(Certificate to that effect to be enclosed)     |   |
| 10) Permanent Two wheeler Driving License (Yes/No) :   | Date of Expiry:   |
| 11) Local/ Non Local<br>Local Status (to produce 4 <sup>th</sup> to 10 <sup>th</sup> Class study Certificates :      |   |

#### **Marks Obtained in Qualifying Examination.**

| Month & year of passing | Total Max. marks/<br>Grade/Points | Marks /Grade/Points<br>obtained | Percentage of Marks<br>Grade/Points / |
|-------------------------|-----------------------------------|---------------------------------|---------------------------------------|
|                         |                                   |                                 |                                       |

|   |  |
|---|--|
| AP Medical Council Registration Number (if necessary of the post) |  |
|---|--|

Address of Communication along with Pin code :

Name :  
House Number :  
Village / Town :  
District :  
Phone/Mobile No. :  
e-mail address :

### DECLARATION

I do hereby declare that all the above facts are true and correct. I further declare that if the above particulars are found incorrect, I shall be liable for termination from service with immediate effect without any notice.

**Signature of the Candidate**

Filling application with attested Xerox Copies of above recruitment sent to the following address by Register post or by Directly submitted to this office on working days (working hours 10 AM to 5.PM)

Office address: District TB Control Office, Room No.63, Government General Hospital Campus,  
Kakinada, E.G.Dt. 533001

**LAST DATE OF RECEIVED APPLICATION : 15.10.2019**

## CHECK LIST

|     |   |        |
|-----|---|--------|
| 1   | Filled-in application form duly signed by applicant                                     | Yes/No |
| 2.  | Attested copy of marks memo of SSC or equivalent certificate                            | Yes/No |
| 3.  | Attested copies of Qualifying Exam certificate.   | Yes/No |
| 4.  | Attested copy of marks memo of All years of the Qualifying Exam                         | Yes/No |
| 5.  | Attested copies of Additional qualification certificate                                 | Yes/No |
| 6.  | Attested copies of experience Certificate   | Yes/No |
| 7.  | Attested copy of latest caste certificate (in case of SC/ST/BC)                         | Yes/No |
| 8.  | Attested copies of study certificates from Class – IV to X where the candidate studied. | Yes/No |
| 9.  | Attested copy of latest Physically handicapped certificate (if applicable)              | Yes/No |
| 10. | Attested copy of certificates supporting Ex Service Man Quota (If Applicable)           | Yes/No |
| 11. | Attested copy of any other document/ certificate produced by the individual             | Yes/No |