

NAME: \_\_\_\_\_

APPLIED FOR

Program:       FCPS               MCPS

Discipline: \_\_\_\_\_

PHOTOGRAPH

**PATEL HOSPITAL**  
A Project of Patel Foundation

## APPLICATION FORM

[FOR RESIDENT'S ONLY]

Your first step towards joining a leading tertiary health care institute

### Instructions:

- I. Please write in capital letters.
- II. Failure to complete this application form fully & correctly may prejudice the applicant's chances of obtaining a Residency Training
- III. Please attach the following documents:
  - a) Your detailed CV
  - b) MBBS Marks Sheets/Degree
  - c) FCPS-I letter from CPSP (if applicable)
  - d) IMM letter from CPSP (if applicable)
  - e) Experience Certificate
  - f) House Job Certificate
  - g) PM&DC Certificate
  - h) CNIC Copy
  - i) Three (3) Passport size photographs
  - j) Copy of Cash Slip/Pay Order (only for Medicine Applicants)
- IV. Applicants are requested to please submit this form with all mentioned documents.



HUMAN RESOURCE DEPARTMENT

ST-18, Block-4, Gulshan-e-Iqbal, Karachi-75300, Pakistan  
Tel: +(92 21) 111-174-174 | Email: hr@patel-hospital.org.pk

## PERSONAL DATA

FATHER / HUSBAND  
NAME:

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DATE OF BIRTH:

	-		-	
(day)		(month)		(year)

PLACE OF BIRTH: \_\_\_\_\_

NIC NO.

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NATIONALITY:

Pakistani       Others \_\_\_\_\_

MARITAL STATUS:

Single       Married       Others \_\_\_\_\_

NO. OF CHILDREN:

\_\_\_\_\_

RELIGION:

Muslim     Christian     Hindu     Others \_\_\_\_\_

PRESENT ADDRESS: \_\_\_\_\_

PERMANENT ADDRESS: \_\_\_\_\_

CONTACT NO:

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MOBILE NO.

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EMAIL: \_\_\_\_\_

PMDC REGISTRATION #:

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EXPIRY DATE:

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## ACADEMIC QUALIFICATION

QUALIFICATION	QUALIFYING YEAR	PERCENTAGE/ DIVISION	INSTITUTION	BOARD
MBBS				
Inter. /A level				
Matric/O level				
Other				

## POSTGRADUATE QUALIFICATION (FCPS-I & IMM)

POSTGRADUATION	DISCIPLINE	QUALIFYING YEAR
FCPS-I		
IMM		
Other		

**EMPLOYMENT RECORD****House Job**

HOSPITAL/ INSTITUTION	DISCIPLINE	PERIOD	
		FROM	TO

**Residency Training**

HOSPITAL/ INSTITUTION	DISCIPLINE	PERIOD		REASON FOR LEAVING
		FROM	TO	

**Professional Experience**

HOSPITAL/ INSTITUTION	DESIGNATION	PERIOD		REASON FOR LEAVING
		FROM	TO	

**EXTRA CURRICULAR/HOBBIES**

ACTIVITIES	REMARKABLE ACHIEVEMENT	REMARKS

HAVE YOU EVER BEEN WORKED WITH PATEL HOSPITAL  
(If yes please provide the details)

**INTERNAL EMPLOYMENT HISTORY**

DESIGNATION	EMPLOYEE NO.	PERIOD		REASON FOR LEAVING
		FROM	TO	

IS ANY OF YOUR RELATIVE WORKING IN PATEL HOSPITAL  
(If yes please provide the details)

NAME	DESIGNATION	DEPARTMENT	RELATIONSHIP

## REFERENCES

1.	NAME:	
	OCCUPATION:	
	ADDRESS (RESIDENTIAL/ OFFICE)	
	CONTACT NO:	
2.	NAME	
	OCCUPATION:	
	ADDRESS (RESIDENTIAL/ OFFICE)	
	CONTACT NO:	

I solemnly declare that the information given in this application is true to the best of my knowledge and I understand that any false statement will render me liable for termination from my residency training.

Date: \_\_\_\_\_ Applicant's signature \_\_\_\_\_

### For office use only

Received By:

Name : \_\_\_\_\_

Signature : \_\_\_\_\_ Date: \_\_\_\_\_