

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

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: _____