ANDHRA PRADESH STATE ROAD TRANSPORT CORPORATION

APPLICATION FORM

Please paste a recent colour passport size photo here

Engagement of Medical Officers
on Contract basis on Consolidated pay
(Ref: Notification No. R3/122(4)/2018-HRD&W,Dt.22.11.2018)

S.No.	Personal Details		
1	Name (As per SSC)		
2	Father's Name		
3	Date of Birth (DD/MM/YYYY)		
4	Gender(Male/Female)		
5	Address for communication		
6	Caste & Sub Caste		
7	E-mail		
8	Mobile No.		
9	Aadhar No		
10	Are you a citizen of India		
11		DD No.	

	Payment Details	Date	
		Drawee Branch	
		Amount	

12. Basic Qualification (MBBS) details :

University & College	
Whether Medical Council of India(MCI) recognized	
Year of Passing with internship	
Date of Registration in AP Medical Council	
Max.Marks in Final Year	
Marks obtained in Final Year	

13. Post Graduation details:

Specify PG Specialization	
University & College	
Whether Medical Council of India(MCI) recognized	
Year of Passing	
Date of Registration in AP Medical Council	

14. PG Diploma details:

Specify PG Diploma	
University & College	
Whether Medical Council of India(MCI) recognized	
Year of Passing	
Date of Registration in AP Medical Council	

15. Experience details:

S. No.	Name of Institution / Hospital where worked	Worked from Date		Designation
		From	To	

16. Certificates enclosed details:

S.No.	Certificate	Whether enclosed Indicate Yes/No
I	SSC Certificate	
Ii	MBBS Certificate	
Iii	MCI Registration Certificate for MBBS	
Iv	PG Diploma Certificate	
V	MCI Registration Certificate for PG Diploma	
Vi	PG Certificate	
Vii	MCI Registration Certificate for PG	
viii	Marks Memos for MBBS	
Ix	Aadhar Card	
X	Certificate of Experience as per proforma enclosed	

Declaration:I certify that I have read the Detailed Notification and I submit that I am eligible for the post. I also certify that the information furnished above is true to the best of my knowledge. I understand that if it comes to light at a later date, that any information furnished above is false or incorrect I am liable for suitable action as deemed fit by the Corporation.

Place:

Date: **Signature of the Applicant**

CERTIFICATE OF EXPERIENCE

This is to certify that Sri _____, S/o/D/o_____whose qualification is _____worked as Medical Practitioner in this Hospital and performed the following duties:

Period of Working		Nature of Duties performed	Remarks
From	To		

Name & Address of the Hospital:

Station:

Date:

Authorized Signatory
with Stamp