INDIAN COUNCIL OF MEDICAL RESEARCH

Division of ECD

Photo

APPLICATION FORM

1. Name of the Project : "COHRPICA" under HIV/AIDS
2. Applying for the Post of :_____
3. Name of the Candidate :_____
4. Father's Name :_____
5. Sex (Male/Female) :_____
6. a) Date of Birth (Date/Month/Year) & age :_____
7. Postal Address (Present) :

8. Permanent Address :

9. Email ID (Mandatory) :_____
10. Mobile No. (Mandatory) :_____
11. Educational Qualification

a) Essential Qualification:

Examination passed	Year of passing	Name of the Board/ University	Class/ Percentage obtained	Subject Studied
10th				
12th				
Graduation				
Post-Graduation				
Other Qualification				

b. Desirable qualification as per advertisement:

c. Work Experience (Total Number of Years):

S. No	Name of the Employer (Name of the office/Institution)	Period (Date/month/year)		Post held and responsibilities
		From	To	

d. Any other Research Experience / Information :

e. Check List

S. No.	Title	(Please tick)
1	Documentary proof of date of birth (PDF/JPG)	
2	All Educational Qualification Certificates (PDF/JPG)	
3	Experience certificate from previous and current employer (PDF/JPG)	
4	Scan copy of Signature (JPG)	
5	Scan copy of Passport Size photograph (JPG)	

DECLARATION

I hereby declare that the information furnished above is true, complete and correct to the best of my knowledge and belief. I understand that in the event of any of the information provided by me are found false or incorrect at any stage, my candidature / appointment shall be liable for cancellation / termination without notice or any compensation in lieu thereof.

Place:

(Signature of the Candidate)

Date: