S.No._____

OFFICE OF THE MEDICAL SUPERINTENDENT
KING ABDULLAH TEACHING HOSPITAL MANSEHRA.

Two Attested Recent Photographs

APPLICATION FORM FOR THE POST_____

1. **Name:_____**
2. **Fathers Name:_____**
3. **Date Of Birth:_____/____/_____ Gender(M/F):_____**
4. **CNIC #:** | | | | | | - | | | | | | | | - | |
5. **Domicile: _____**
6. **Temporary / Postal Address:_____**

   _____
7. **Permanent Address:_____**

   _____
8. **Contact No: Phone:_____ Mobile No:_____**

ACADEMIC QUALIFICATION				
S.No	Name of Certificate/ Degree	Institute	Year of Passing	Marks Obtained
PROFESSIONAL QUALIFICATION				
S.No	Name of Diploma/Certificate	Institute	Year of Passing	Marks Obtained

PROFESSIONAL EXPERIENCE						
S.No	Department/ Organization	Duration				**Year**
		From	To	Total		

Certification and Achievements: _____

_____

Dated: _____ Signature of Candidate: _____

Received By:_____