

APPLICATION FORM

Application for Engagement of Authorized Doctor on contract basis

1. Name in full: Shri/Smt./Ms. (To be given in block letter, Surname to be stated first) 2. Father / Husband's Name: 3. (a) Detailed Address:	Applicant's Passport size coloured Photograph				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">Residence</th> <th style="width: 50%;">Hospital/Clinic where presently practicing</th> </tr> <tr> <td style="height: 40px;"></td> <td></td> </tr> </table>	Residence	Hospital/Clinic where presently practicing			Applicant's Signature
Residence	Hospital/Clinic where presently practicing				

(b) Contact Details:

- i) Mobile No. :
- ii) Landline No.:
- iii) Email id :

(c) Approximate distance from the Bank's building located at:

Premises	Indian Bank, Zonal Office Thiruvananthapuram 2nd Floor, Indian Bank Towers, M G Road, Thiruvananthapuram, Kerala		
From	Residence	Hospital	
Distance (in KM Approx.)			

4. a.) Date of Birth:

D	D	M	M	Y	Y	Y	Y

b.) Age:

(Age as on)

5. Place of Birth and Domicile:

6. Nationality:

7. Whether belongs to SC/ST/OBC/EWS/Unreserved (General):

8. Educational Qualifications:(Indicate degree / diploma obtained, In the order of highest to least)

Degree / Diploma	University / Board	Month & Year of passing	Class /Rank secured

9. Details of any other professional course completed in Medical field:

10. Details of experience - (Experience after graduation only should be stated)

SL. No.	Hospital Name	From	To	Period	
				Year/s	Month/s
In Hospital (as a Physician)					
1					
2					
3					
As General Practitioner					
1					
2					
3					

11. Any other factor which applicant would like to bring into account in support of his/her application:

I hereby declare that the information and particulars given by me in this form are true and correct. I also note that if any of the above statements are incorrect or false or if any material information or particulars has been suppressed or omitted there from, my medical consultancy services are liable to be terminated without notice or compensation in lieu of notice. I agree to the terms & conditions mentioned under Annexure – I and code of conduct as per Annexure – II.

Date:

Place:

(Name & Signature of the applicant)

Instructions:

1. All the details in this form must be filled by the applicant.
2. Applications which do not contain the full details/particulars are liable to be rejected.
3. Attested copies of certificates regarding ID & Address proof, age, educational qualifications, experience etc. should accompany the application.
4. Duly signed copy of Annexure – I & Annexure – II is required to be submitted along with application
5. If the candidate is working as a Medical Officer for any institution, the details thereof and working hours therein should also be indicated.

CHECKLIST/DECLARATION

1.	Name	
2	Residential address	
3.	Qualification*	
4.	Date of Birth and Age as on date of submission of application	
5.	Honorarium expected	
6.	Venue	Indian Bank Office & clinic/ Hospital wherever practising
7.	No. of hours in a day agreed to attend staff members (Minimum 2 hours)	
8.	No. of days in a week agreed to attend staff members (Minimum 3 days)	3 / 4/ 5 / all working days
9.	Whether Doctor will permit staff members/family members to avail his consultation in own clinic during working hours of the clinic	YES / NO
10.	Whether Doctor will assist the Indian Bank Office in processing medical bills whenever opinion is sought.	YES / NO
11.	Whether Doctor is agreeable for initial contract of three years and renewable yearly thereafter on mutually agreed terms.	YES / NO
12.	Whether Doctor is agreeable for maintaining of log of patients attended.	YES / NO

*Please enclose relevant papers/Degree/Registration

Date:

Signature of applicant