

ORAL HEALTH SCIENCES CENTRE
POSTGRADUATE INSTITUTE OF MEDICAL EDUCATION & RESEARCH
CHANDIGARH
APPLICATION FORM

1. **Name of the Applicant** _____

2. **Father's Name** _____

3. **Date of Birth** _____

4. **Gender : M/F** _____

5. **Educational Qualifications :**

Affix Photograph

S.No.	Academic Qualification	Name of Institution	Board / University	Course Duration / Yr. of passing out	Division / Grade / % of marks.	Attempt

6. Experience :

S.No.	Designation	Name of Institution/Employer	From	To

7. Research / projects undertaken:

8. Training / Short course attended:

9. Award and Achievements (if any):

10. Publications:

11. Why you want to work in this project:

12. Yours expectations after being part of this project:

13. Contact Details :

- a) Mailing Address _____
- b) Permanent Address _____
- c) Telephone Number(Res)_____ (Mob)_____
- d) Email-ID_____

14. Documents to be enclosed : Self attested (Please Tick)

- a) Degree/Diploma/Certificate ()
- b) Experience Certificates ()
- c) Age Proof ()
- d) Copy of Publications ()
- e) Any Other supporting document ()

15. Undertaking :

I hereby certify that all the information given above is true to the best of my knowledge. If any of the above information is found to be incorrect at any stage, I shall be liable to be disqualified / terminated from the service.

Date : _____

Place : _____

Signature of the Applicant