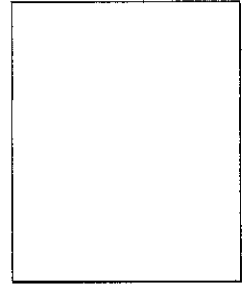


APPLICATION FOR THE POST OF MEDICAL OFFICER UNDER OFFICE OF
MEDICAL SUPERINTENDENT, SOLAPUR MAHARASHTRA EMPLOYEES
STATE INSURANCE SOCIETY HOSPITAL SOLAPUR
Ph.No. 0217-2601747, Email- solapur.esis@gmail.com

Walk in Interview for Post of Specialist

1. Name in full (in block letters):
2. Fathers/Husband's Name:
3. Date of Birth (DD/MM/YYYY) :
4. Religion:
5. Caste :
6. Category :
7. Mailing address:
8. (a) E-Mail :
- (b) Mobile No. :
9. Residential address:
-
10. Permanent address:
11. Sex: Male / Female
12. Date of Registration in State medical council:



13. Essential Educational and Professional Qualification (graduate level onwards)

| Name & address of college | University | Duration | | Degree/ Examination Passing year | Subject | Percentage of Marks obtained |
|---------------------------|------------|----------|----|----------------------------------|---------|------------------------------|
| | | From | To | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

DOCUMENTS TO REQUIRED:

1. Valid MCI / State medical council registration certificate
2. Matriculation Certificate for Age Proof
3. Proof of Educational Qualification
4. Caste Certificate / Caste Validity
5. Experience Certificate (if available)
6. Copy of Pan card, Aadhar card Xerox
7. Two Photographs

All copies of above documents are to be self attested before submission.

I hereby declare that all the statements made in this application are true, complete and correct to the best of my knowledge and belief.

I understand that in the event of any information being found false or incorrect at any stage, my candidature / appointment shall be liable to be cancelled / terminated summarily without notice or any compensation in lieu thereof.

Place:

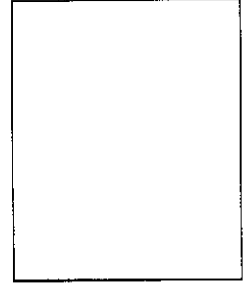
Signature of Candidate

Date:

APPLICATION FOR THE POST OF MEDICAL OFFICER UNDER OFFICE OF
MEDICAL SUPERINTENDENT, SOLAPUR MAHARASHTRA EMPLOYEES
STATE INSURANCE SOCIETY HOSPITAL SOLAPUR
Ph.No. 0217-2601747, Email- solapur.esis@gmail.com

INTERVIEW FOR POST OF PGMO

1. Name in full (in block letters):
2. Fathers/Husband's Name:
3. Date of Birth (DD/MM/YYYY) :
4. Religion:
5. Caste :
6. Category :
7. Mailing address:
8. (a) E-Mail :
- (b) Mobile No. :
9. Residential address:
-
10. Permanent address:
11. Sex: Male / Female
12. Date of Registration in State medical council:



13. Essential Educational and Professional Qualification (graduate level onwards)

| Name & address of college | University | Duration | | Degree/ Examination Passing year | Subject | Percentage of Marks obtained |
|---------------------------|------------|----------|----|----------------------------------|---------|------------------------------|
| | | From | To | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

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Place:

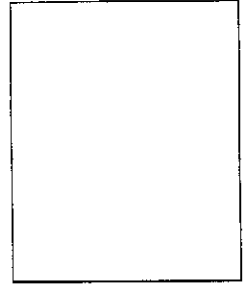
Signature of Candidate

Date:

**APPLICATION FOR THE POST OF MEDICAL OFFICER UNDER OFFICE OF
MEDICAL SUPERINTENDENT, SOLAPUR MAHARASHTRA EMPLOYEES
STATE INSURANCE SOCIETY HOSPITAL SOLAPUR**
Ph.No. 0217-2601747, Email- solapur.esis@gmail.com

INTERVIEW FOR POST OF RESIDENT RADIOLOGIST & RESIDENT ANAESTHESIOLOGIST

1. Name in full (in block letters):
2. Fathers/Husband's Name:
3. Date of Birth (DD/MM/YYYY) :
4. Religion:
5. Caste :
6. Category :
7. Mailing address:
8. (a) E-Mail :
- (b) Mobile No. :
9. Residential address:
-
10. Permanent address:
11. Sex: Male / Female
12. Date of Registration in State medical council:



13. Essential Educational and Professional Qualification (graduate level onwards)

| Name & address of college | University | Duration | | Degree/ Examination Passing year | Subject | Percentage of Marks obtained |
|---------------------------|------------|----------|----|----------------------------------|---------|------------------------------|
| | | From | To | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

DOCUMENTS TO REQUIRED:

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Place:

Signature of Candidate

Date: