



OFFICE OF THE MEDICAL SUPERINTENDENT

SAIDU GROUP OF TEACHING HOSPITALS SAIDU SHARIF SWAT

Ph: 0946-9240126-27, Fax: 0946-9240122

APPLICATION FORM

1. Apply for Post: _____
2. NAME: _____
3. Father's Name: _____
4. CNIC No: _____
5. District of Domicile: _____
6. Date of Birth: _____ Mobile No. _____
7. Permanent Address: _____
8. Present Address: _____

ACADEMIC INFORMATION:

| Degree/Certificate | Board/University | Marks Obt/Total Marks or CGPA | Grade/Division | Year of Passing |
|--|------------------|----------------------------------|----------------|--------------------|
| SSC | | | | |
| HSSC | | | | |
| Bachelor (2 years) Bachelor (4 years) | | | | |
| Master | | | | |
| If any other | | | | |

(Attached Documents)

EXPERIENCE:

| Department type | Department Name | Job Title | Starting Date | Ending Date |
|-----------------|-----------------|-----------|---------------|-------------|
| | | | | |
| | | | | |

Note: Only Government/Semi-Government experience will be accepted.

Undertaking By the Applicant

I _____ D/S/W/ of _____ do hereby solemnly declare that the information given in the form are true and correct to the best of my knowledge and belief and I understand that if any information is found wrong/untrue, disciplinary action will follow which may result in cancellation of my job Application.

Signature of the Candidate: _____

Date: _____