



GOVERNMENT OF INDIA
Ministry of Health & Family Welfare

NATIONAL INSTITUTE OF PUBLIC HEALTH TRAINING & RESEARCH

MUMBAI CAMPUS: 332, S.V.P. Road, Girgaon, Khetwadi, Mumbai – 400 004.
TEL.: 2388 1724 / 2389 3165 **FAX NO.** (91) 22 – 2386 2736 **Email:** director.fwtrc@nic.in
NAVI MUMBAI CAMPUS: Plot No. 6 & 6 A, Sector 18, New Panvel (E) – 410 218.
Website: www.fwtrc.gov.in

APPLICATION FORM

PHOTO

Name of the Course: POST GRADUATE DIPLOMA IN HOSPITAL MANAGEMENT

1. Name in Full:
(In Block Letters)
2. Sex:
3. Age (as on 31st May 2023):
4. Marital Status:
5. Designation of the Present Post:
6. Nationality:
7. a. Present Address (to which communication to be sent):

b. Permanent Address (If different from above):

c. Phone No. (Office): _____ Phone No. (Residence): _____
Mobile No.: _____

d. Email (Compulsory): _____

8. Date & Place of Birth:

Date of Birth

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Place: _____

9. Do you belong to Scheduled Caste / Scheduled Tribe / OBC / EWS:

YES	NO
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If Yes,

Scheduled Caste / Scheduled Tribe / OBC / EWS:

Sub-caste: _____

(Please attach Valid Caste Certificate & OBC Non-Creamy Layer Certificate from the District Authority, EWS Certificate from competent authority otherwise application will be treated as general category.)

10. Academic record:

Give particulars of all examinations and degrees obtained:

Exam / Degree	Board / Institution / University	Medium of Examination	Year of Passing	Division / Class with % of marks	Subject (s) Offered

11. Employment Record (If Any): (Please attach Experience certificate from Employer.)

Employer	Post held	From (Date)	To (Date)	Salary last Drawn	Reasons for leaving the post

12. List your important present job responsibilities: -

1.

2.

3.

13. Give reasons in brief as to why you seek admission and your expectation from this training course: -

(1)

(2)

(3)

14. Give names, occupations / positions, contact numbers and addresses of two references, other than your relatives, who are in a position to give information about you and your work: -

I	_____	II	_____
	_____		_____
	_____		_____
	_____		_____

DECLARATION BY THE APPLICANT

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

SIGNATURE OF THE APPLICANT

Place & Date:

EMPLOYER

(FOR USE IN THE CASE OF SPONSORED CANDIDATES ONLY)

In case the candidate is selected for the training at the National Institute of Public Health Training and Research, Mumbai, whether the State or Central Govt. or any other agency with whom the applicant working:

- a) Will relieve him / her? : YES / NO
b) Will provide him / her deputation Allowance or / and pay during : YES / NO
period of training?

Certified that Mr / Mrs / Miss _____ holds a post in this Department / Office / Institution / Organisation and that the statement made by him / her in this form are correct to the best of my knowledge and belief. I recommend his/ her admission to the training programme of the Centre.

SIGNATURE:

(Office seal)

DESIGNATION:

Department / Office / _____

Institution / Organisation _____

Phone No. (Office): _____ Fax No.: _____

Mobile No.: _____ E-mail ID: _____

PLACE:

DATE:

ENCLOSURES TO BE ATTACHED ALONG WITH APPLICATION FORM:

1. SSC certificate (attested copy)
2. Graduation certificate (attested copy)
3. Age proof (attested copy)
4. Caste certificate along with validity certificate (attested copy)
5. Non creamy layer certificate for OBC candidates (attested copy)
6. EWS Certificate from competent authority
7. Experience certificate
8. Forwarding letter from Competent Authority
9. Medical fitness certificate from the District Civil Surgeon or equivalent Competent Medical Authority.

Applications should be sent by registered post to the Director, National Institute of Public Health Training and Research, 332, S. V. P. Road, Girgaon, Khetwadi, Mumbai - 400 004 on or before **4th June 2023**.