FORM No. SHCC/DHR&A/RECRUITMENT/03

NOTE: (1)- ***The fields with asterisk (*) must be completed with valid information.***

(2)- ***Please attach the attested photocopies of the following mandatory documents along with this form:***

- ☐ ***Copy of CNIC.***
- ☐ ***Copy of required qualification.***
- ☐ ***Copy of domicile.***
- ☐ ***Copy of experience certificate.***

SINDH HEALTH CARE COMMISSION (SHCC)

Quality Care for All

Recent Photo
1 ½" x 2"
(*Attested on front & back*)

JOB APPLICATION FORM

A. POST APPLIED FOR: | **ASSISTANT** |

B.	**ADVERTISEMENT NO:**	**NEWPAPER NAME**	**DATE**	DD	MM	YYYY

C. PERSONAL INFORMATION:

Name:	S , D , W/O:	
Date of birth *:	Religion:	Male☐ Female☐ Tr.☐
CNIC No: – –		
Present address *:		
Permanent address:		
Phone No: Landline:	Mobile *:	
Email *:	Marital Status:	Domicile *:

D. ACADEMIC QUALIFICATION

S No.	*QUALIFICATION **	*INSTITUTION*	*YEAR*		*MAJOR SUBJECTS*
			from	*to*	

E. EMPLOYMENT & EXPERIENCE *(Starting from current / the most recent)*:

S No.	*Designation*	*Institution/Organization*	*From*	*To*	*Major Responsibilities*	
						Govt. ☐ Semi Govt. ☐ Private ☐ Monthly Salary ________

F. CERTIFIED TRAINING COURCES ATTENDED:

S No.	*NAME OF TRAINING*	*INSTITUTION*	*From*	*To*

G. SKILLS:

S No.	*DESCRIPTION*	*Institution where acquired*

H. LANGUAGES:

S. No	*LANGUAGES*	*READING*	*WRITING*	*SPEAKING*

I. ADDITIONAL INFORMATION YOU WISH TO ADD, *(if not covered above)*:

J. PROFESSIONAL REFERENCES *(Two)*:

S. No	*NAME*	*TITLE / DESIGNATION / ORGANIZATION*	*ADDRESS, CONTACT NO.& EMAIL*
1			
2			

K. WHEN CAN YOU JOIN, IF SELECTED: ____

L. CERTIFICATION:

"I solemnly affirm that:

1- *all the information submitted by me through this application is correct & true to the best of my knowledge & belief. I understand that if any false information, concealment of any relevant fact or misrepresentation is discovered at any stage, my application may be rejected and, if I am selected. my employment may be terminated without any prior notice"*

2- *I am free from any conflict of interest as envisaged in Sindh Healthcare Commission act 2013.*

Date: ____________________

Signature of Applicant: _____________________

Name: ___________________________________

Post applied for: __________________________

(Do not write below this line)

FOR OFFICE USE ONLY AT SHCC, Karachi

FORM SCRUTINISED BY:		**FORM VERIFIED BY:**	
Signature:		Signature:	
Name:		Name:	
Designation:		Designation:	

Eligible (Yes/No):	Reasons if not eligible:
Interview date:	Selected: (Yes/ No):
Joining date:	Gross monthly salary: Rs.

Appointing Authority:

Name: _______________________________

Designation: ___________________________

Stamp

____
Signature

NOTE: *The filled in form be mailed or deposited at the following address: Assistant Director (HR)*

HEAD OFFICE SINDH HEALTHCARE COMMISSION, 2ND FLOOR, BLOCK C, FTC BUILDING, SHAHRAH E FAISAL, KARACHI.

Phone No. 021-38656000, Helpline No. 0800-07422, UAN. 021-111-117-422