

# PDF Application Form

Application for fellowship in

## Personal Information

Affix Passport  
Size  
Photograph

**Name:**

**Parent / Spouse Name:**

**Age:**

**Date of Birth:**

**Sex:** ☐ M / ☐

**F Present**

**Address:**

**Permanent Address:**

**Phone Number(s):**

**Email ID:**

**District and State:**

**Mother Tongue:**

**Nationality:**

**Marital Status:** ☐ Married ☐

**Unmarried Children:**

**OC/BC/SC/ST/MBC:**

**Languages Known:**

No.	Language	Speak	Read	Write
1.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Medical Qualifications

### 1. Basic Medical Degree:

<b>Examination passed:</b>	
<b>Institute:</b>	
<b>Year of Passing:</b>	<b>Division/Percentage:</b>
<b>Date of Registration:</b>	<b>M.B.B.S Registration No:</b>
<b>State &amp; Country where registered:</b>	

### 2. Ophthalmology

**Residency/Post-Graduation: (Attach a copy of the mark sheet)**

<b>Examination passed:</b>		
<b>Institute:</b>		
<b>Year of Passing:</b>	<b>Division/Percentage:</b>	<b>No. of Attempts:</b>
<b>Date of Registration (if applicable):</b>	<b>Registration No:</b>	
<b>State &amp; Country where registered:</b>		

**Brief Note on the Thesis work:**

### 3. Professional Experience

**Total Years of Experience:**

<b>Name of Organization</b>	<b>Designation</b>	<b>Period of Tenure (with dates)</b>

**Other qualifications:**

### 4. Surgical Experience

<b>Surgical Procedure</b>	<b>Number of surgeries performed under supervision</b>	<b>Number of surgeries performed Independently</b>
<b>ECCE</b> <b>SICS</b> <b>Phacoemulsification</b> <b>Retinal Lasers</b> <b>Pterygium Excision with autograft</b> <b>Others</b>		

## **5. Publications & Research**

**6. Name, Designation & Address of 3 persons (under whom you have worked/studied), whom we can contact for reference:**

<b>S.No</b>	<b>Name &amp; Designation</b>	<b>Address</b>
<b>1.</b>		
<b>2.</b>		
<b>3.</b>		

**7. Briefly explain your choice of specialty and what you expect to gain from the fellowship programme (150 words)**

**8. Certificate copies to be attached with this form:**

- 1. MBBS Degree Certificate**
- 2. DO and or MS / DNB Certificate**
- 3. Postgraduate Degree Mark Sheet**
- 4. MCI / State Council Registration Certificate**
- 5. Valid ID proof (Aadhar card/ Passport/ PAN card/ Voter ID)**

**Signature of the candidate**

**Date:**

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**For Office Use:**

☐ **Selected**

☐ **Not Selected**

**Period: From:**

**To:**

**Remarks:**

**Signature**