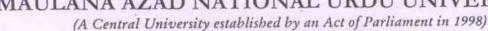
मोलाना आज़ाद नेशनल उर्दू यूनिवरिरिटी مولانا آزاد نیشتل اُر دولونیورسی MAULANA AZAD NATIONAL URDU UNIVERSITY



Sink (33 (P.5) Fig.)

*Please tick any one

A Central University established by an Act of Parliament in 1998)

(Accredited "A" Grade by NAAC)

PROFORMA FOR HEALTH CARD

	II. Health Card in case of Loss / Dam III Health Card for Pensioners	age / Up gradation etc.
	TO BE FILLED IN	BLOCK LETTERS ONLY
1.	Name	
2.	Father's / Husband's Name	:
3.	Designation	
4,	ID Card No	\$
5.	Place of Posting / Department	:
6.	Date of Joining	1-
7.	Date of Initial Joining	:
8.	Date of Superannuation/End of ten	ure:
9.	Present Pay Level	
10.	Last Pay (in case of Pensioners)	1
11.	Type of Appointment: Regular/Ter	nure/Lien/Deputation (Please specify)
12.	Date of Birth:	13. Blood Group:
14.	Contact No:	15. E-Mail:
16.	Residential Address:	

If Yes, Date of completion of Deputation:

18.

 Details of Family: (Please see definition of family before filling up this column carefully & attach proof of age)

SI.No.	Name of Family Member	Relationship	Date of Birth	Age as on	Blood Group	Marital Status (in case of Brother & Sister)
1.						
2.						
3.	Yuffee	min Ju a		Langi		
4.						
5.	,					
6.						
7.			>	الساو		
8.						

20.	Are all the persons whose names are mentioned in the column No.19 are De	pendants
-21	upon you? In case brother & sister age, marital status should be mentioned	

(Yes/No)

(Please attach proof of their dependency with you, like copy of Ration Card/Election ID/ Passport/Aadhaar Card/Identity Card issued by College/School/University/Bank Passbook etc.)

21. Are all the Persons, whose name are mentioned in column No.19 are Residing with you?

(Yes/No)

If not, place of their Residence:

 Enclose one group photograph (POST CARD SIZE) of the applicant with all dependants whose name are proposed to be included as part of the family.

UNDERTAKING

I undertake to intimate to the university immediately, if there is any change in dependency criteria of my family members including in this application form. If I fail to intimate and if the university comes to know of the change then the medical facility is liable to be withdrawn by the university and the university and appropriate authority will be free to initiate action against me.

I undertake to surrender the Health Card (s) on my leaving the university on transfer, retirement, termination, resignation or on ceasing to be eligible for medical benefits.

I certify that the information furnished by me in this application is correct and that no information has been concealed or has been misrepresented and I stand by the same.

Encls:-

484	24	A THE REAL PROPERTY.	14	Library.	ST- COLD	
(1)	Proof	OT	de	nen	aency	V

- (ii) Proof of age of dependents/son/disability certificate (if applicable)
- (iii) Surrender Certificate of Health Card/CGHS card while in service(if applicable)
- (iv) Attested copies of PPO & last pay certificates (if applicable)
- (v) Group photograph of the applications with all dependents (Post Card Size)

1 Prof./Dr./Mr./Mrs		agree to de	educt cost /
price of the printing of my Health Card	I from my salary.		

Date:	Sig	gnature of the	Applican

(To be filled by ER-I / ER-II Section)

	The infor	natio	on fu	rnished by the a	pplicar	nt has	been veri	ified fro	m the	office	records	and
found	correct.	It		recommended		the			may	be	issued	to
Prof./D Design	r./Mr./Mrs. ation						Dept./C	TE/Sec	tion/Po	lytech	nic/Cente	r/
Model	School					in t	his Unive	rsity.	V 7.			

Dealing Assistant

Section Officer/A.R.

Section Head