HEALTH DEPARTMENT EMPLOYEE ON-BOARDING FORM

Basic Details

Prefix*----------

First Name*----------Middle Name----------

Last Name*----------Gender*----------

Date of Birth*----------Height (CM/Feet/Inch) *----------

Father's Name*----------Mother's Name*----------

Identification Mark*----------

Marital Status*----------

Spouse Name (Husband/Wife) ----------

Attach Passport Size Photograph

Disability Details (If Applicable)

Disabled* ☐ Yes ☐ No Type of Disability (If selected Yes) ----------

Percentage of Disability----------

Personal Details

Blood Group---------- Email---------- Mobile Number*----------

Nationality---------- PAN No*---------- GPF/PRAN Type*----------

Aadhar Ref No---------- Social Category----------

Permanent Address*

State*----------District*----------Pin Code*----------

Employee Official Details

Employee Type*---------- Service Type*----------

Cadre*---------- Parent Department*----------

Current Department*---------- Current Designation*----------

Current Office*---------- Source of Recruitment*----------

Order issuing Office/Authority*---------- Appointment Order No*----------

Appointment Order Date*---------- Joining/Charge Taken Date*----------

Joining Time*----------

Certification: I, the undersigned, certify that to the best of my knowledge and belief, this form is filled correctly.

---------- **Sign. ----------**

Sign controlling officer with stamp