



**ICMR-VECTOR CONTROL RESEARCH CENTRE
MEDICAL COMPLEX, INDIRA NAGAR
PUDUCHERRY-605 006**

Phone No.0413-2272396, 2272397

Email: director.vcrc@icmr.gov.in Website: <https://vcrc.icmr.org.in>

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Note: This application form should be filled in by candidate's own handwriting.
All information must be given in words and not by dashes and dots.
No column should be left blank. Incomplete application will be rejected.

Affix a recent
passport size
photograph
(3.5cm x 4.5cm)

Application for the post of _____

“Evaluation of sampling strategies for assessing the endemicity status of lymphatic filariasis in a non-MDA district”

01. Name in Full: Mr./Miss/Mrs./Dr. _____
(IN CAPITAL LETTERS)

02. Address: (A) for communication: _____

(B) Permanent: _____

(C) Mobile No. _____

E-Mail: _____

03. Date of Birth _____ (DD/MM/YYYY) Age as on 26.09.2022 _____ (YY/MM/DD)
(copy of certificate duly self-attested must be attached)

04. Sex: Male Female (Please ✓ the appropriate box)

05. Marital status: Unmarried Married (Please ✓ the appropriate box)

06. Category : SC ST OBC EWS UR (Please ✓ the appropriate box)
(attach a copy of community certificate duly self-attested in support of your claim)

07. Educational Qualification: **(attach self-attested copies of all certificates)**

Sl. No	Examination Passed	Year of passing	Name of the Board/ University	Class/ % of marks obtained	Subject(s) taken	Regular/Distance Education
1.	SSLC/Matric					
2.	HSC					
3.	Degree					
4.	P.G					
5.	Any Other					

08. Languages known:

Languages	Read only	Speak only	Read and Speak	Examination Passed

09. Previous Service Details: **(attach self-attested copies of all certificates)** (Chronologically starting from the present employer)

Name of the Employer	Date of		Post held	No. of years' experience	Nature of duties
	Joining	Leaving			

10. If selected what notice would you require for joining the post: _____

11. Additional Information, if any

DECLARATION

I hereby declare that the information furnished above is true, complete and correct to the best of my knowledge and belief. I understand that in the event of any of the information provided by me are found false or incorrect at any stage, my candidature / appointment shall be liable for cancellation / termination without notice or any compensation in lieu thereof.

SIGNATURE OF CANDIDATE

DATE:

PLACE:

CHECK LIST

Tick whether the self-attested copies of the certificate and other documents in support of the application are enclosed, as given under.

- | | | |
|---|---|--------------------------|
| 1. Certificate for proof of age | : | <input type="checkbox"/> |
| 2. Certificates in support of Educational Qualifications: | | <input type="checkbox"/> |
| 3. Certificate for proof of Experience, if any | : | <input type="checkbox"/> |
| 4. Community Certificate (OBC/SC/ST) | : | <input type="checkbox"/> |