



**Annexure-I**

**APPLICATION FORM FOR Short Term/ Long Term Training  
UTTAR PRADESH UNIVERSITY OF MEDICAL SCIENCES  
SAIFAI, ETAWAH – 206130**

No. F. \_\_\_\_\_

(for Office use only)

Dated: \_\_\_\_\_

Subject: Application for (Please ✓ one only)	Short-Term Training (up to 3 months) <input type="checkbox"/>	Long-Term Training (more than 3 months) <input type="checkbox"/>
Training Area & Objective	_____	
	_____	

1. Name (in Capital Letters) : \_\_\_\_\_

2. Father's Name : \_\_\_\_\_

3. Date of Birth : \_\_\_\_\_

4. Permanent Address : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Correspondence Address : \_\_\_\_\_

6. A) Mobile No.: \_\_\_\_\_ B) Email id: \_\_\_\_\_

7. C) Aadhar No.: \_\_\_\_\_

8. Academic Qualification (Diploma/ Graduation/ Post Graduation): \_\_\_\_\_

9. Whether Sponsored by authority: (Please ✓one only): YES  NO

10. Sponsored Authority Name (if applicable): \_\_\_\_\_

11. Sponsoring Authority status: \_\_\_\_\_  
(Government, Semi-Government, Autonomous, Public Health Sector Organization, Statutory Council/ Commission approved Inst.)

12. If Employed/Working : \_\_\_\_\_  
(Name of Current Post / Designation Held & Date of Joining the Post)

13. Working Experience (if any) : \_\_\_\_\_

14. Specific Period & Dates of Training : \_\_\_\_\_  
(Period/Duration of Training (in months), Start & End Dates of Training)

15. Discipline/Department: \_\_\_\_\_  
(Name of the Department in which training is required – only one department name is to be specified)

DECLARATION: I do hereby declare that the information furnished above is true and correct to the best of my knowledge and I shall abide by the rules and regulation of the UPUMS, Saifai.

**SIGNATURE OF THE APPLICANT**

**Sponsoring Authority (With Seal)**

Please attach the following with this filled-in application form:

- i) Sponsoring Authority letter in Original. (if applicable)
- ii) Self Attested copies of all Certificates/Testimonials related to qualification and experience.
- iii) Copy of the Curriculum Vitae
- iv) Identification proof: Aadhar card (self attested) copy.

**(The candidate, is advised to fill up each & every column of the application form as per the instructions/guidelines given)**

**Important note: To be submitted by post or in person to: Concerned Dean (Faculty of Medicine/ Dental Sciences/ Paramedical Sciences/ Nursing/ Pharmacy), Uttar Pradesh University of Medical Sciences, Saifai**

**INCOMPLETE APPLICATIONS WILL BE REJECTED**