# Government of Nepal

**Ministry of Health and Population**

# Bharatpur Hospital

Recent Color PP size photo (without cap & glasses)

Bharatpur, Chitwan

Tel: 977-056-597003

**Application for Fellowship Program**

## (2023/2024)

**Program Applying For:** (  *Please Tick One*) **Category of Enrollment:** (  *Please Tick One*)

|  |  |
| --- | --- |
|  | Spine Surgery |
|  | Neonatology |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
|  | Open |
|  | Institutional Sponsorship |
| *Sponsoring Institution:* |
| Name: |
| Address: Contact No.: |

Full Name:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Date of Birth:

Gender:

Marital Status:

|  |  |  |  |
| --- | --- | --- | --- |
|  | dd | mm | yyyy |
| A.D. |  |  |  |  |  |  |  |  |
| B.S. |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| Male |  |
| Female |  |
| Other |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Unmarried |  | Married |  |
| Divorced |  | Widowed |  |

Permanent Address:

Province: District: VDC/MP: Ward No:

**Temporary Address:** (*if different from Permanent*)

Province: District: VDC/MP: Ward No:

Contact Detail:

Mobile:

Landline Tel:

Email

**Name of Spouse:** (*if married*) **Number of Children with Age:**

Name of Parents/Guardian/Spouse: \_

Educational Training and Professional Qualifications:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Degree/Qualification** | **Name & Address of Institution/University** | **Duration** | **Period of Study** | **Grade/Percentage** |
| MBBS |  |  |  |  |
| Postgraduate |  |  |  |  |
|  |  |  |  |  |

Work Experience after Completion of MBBS:

|  |  |  |
| --- | --- | --- |
| **Name & Address of Institution** | **Job Title** | **Date** (From - Until) |
|  |  |  |
|  |  |  |
|  |  |  |

Work Experience after Completion of Post graduation:

|  |  |  |
| --- | --- | --- |
| **Name & Address of Institution** | **Job Title** | **Date** (From - Until) |
|  |  |  |
|  |  |  |
|  |  |  |

Names of 2 Persons for Your Character Reference:

|  |  |  |  |
| --- | --- | --- | --- |
| **SN** | **Name of Referees** | **Institution** | **Contact No.** |
| 1. |  |  |  |
| 2. |  |  |  |

***Declaration*:**

I certify that the above information is true to the best of my knowledge, and I understand that any false

Information or important information not included will be grounds for immediate dismissal. I therefore authorize the Bharatpur Hospital to investigate my statements. I also declare that I agree not to do any type of private practice until I complete my fellowship. I will follow the rules and regulation of Bharatpur Hospital.

**Date:**

**Signature of Applicant:**

Documents to be submitted along with this form:

|  |  |  |
| --- | --- | --- |
| 1. | Curriculum Vitae |  |
| 2. | Post-graduate Degree Certificate |  |
| 3. | NMC Specialty Registration |  |
| 4. | MBBS Certificate |  |
| 5. | Citizenship Certificate |  |
| 6. | Sponsorship Letter (for sponsored candidate) |  |
| 7 | 1 year Post MD/MS Work Experience |  |

**Form Verified by:**

(For Official Purpose Only)

Registration No.: .................

Signature: Name: Designation: Date:

# Government of Nepal

Recent Color PP size photo (without cap & glasses)

**Ministry of Health and Population**

# Bharatpur Hospital

Bharatpur, Chitwan, Nepal Tel: 977-056-597003

**Application for Fellowship Program**

## (2023/2024)

Full Name:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Address:

Program applying for:

 □ Spine Surgery □ Neonatology

Category of Enrollment:

* Open □ Institutional Sponsorship (*Sponsoring Institution:* )

Date: Signature of Applicant:

***Please Note:***

* + You must bring this "Admit Card" during the entrance examination.
	+ You must arrive 15 minutes before the entrance examination.
	+ No electronic devices/gadgets are allowed during the entrance examination.

***For Official Purpose only:***

Registration No.:

Date of Entrance Examination: Issuing Authority:

Date of Issue: