INFORMATION TO BE PROVIDED FOR ISSUING NEW MEDICAL I-CARD*

Name: ____

Employee ID: _____________________________________

Department: _____________________________________

Designation: _____________________________________

Date of Birth: ____________________________________

Blood Group: _____________________________________

Pay in the Pay Band (without Grade Pay): _________________________________

Address: ____

Contact No.: _______________________________

Affix one Stamp size digital photograph with good resolution

Put your Signature in Black Ink in the box provided above

Dependants

Name:____________________
Relationship _______________
Date of Birth:______________
Blood Group: ______________

Name:____________________
Relationship _______________
Date of Birth:______________
Blood Group: ______________

Name:____________________
Relationship _______________
Date of Birth:______________
Blood Group: ______________

Name:____________________
Relationship _______________
Date of Birth:______________
Blood Group: ______________

Name:____________________
Relationship _______________
Date of Birth:______________
Blood Group: ______________

Name:____________________
Relationship _______________
Date of Birth:______________
Blood Group: ______________

* Information will be verified and supporting documents to be produced if asked for.