ANNEXURE -B

PROFORMA FOR REPRESENTATION

(The fields those are applicable only to be furnished)

1	Name 1) English (In Capital) 2) Malayalam		: :	
2	PEN		:	
3	Rank Number in the Provisional Seniority list of Asst Surgeon		:	
4	Date of Birth		:	
5	Designation		:	
6	Present Station with District		:	
7	Qualifications 1) General 2) Additional, if any		: :	
8	Advice Number & Date, with serial number (copy should be enclosed)		:	
9	Appointment Order number & Date (copy should be enclosed)		:	
10	Whether availed Extension of joining time, if so, i) Period ii) Date of J/D after the extension of Joining time (copy of the order should be enclosed.)		:	
11	Date of entry in HSD		:	
12	Whether entered on LWA/ unauthorized absence before declaration of probation		:	
	i)	If answer is Yes in column No.12 furnish the details of LWA/ Unauthorized absence.	:	
		a) Nature of LWA	:	
		b) Period of LWA/unauthorized Absence	:	
		c) Date of rejoining after LWA/ Unauthorized absence (copy of the RTC should be enclosed)	:	

		d) Sanction order No. & Datefor LWA/Regularizing order No. & Date for unauthorized absence (copy of the order should be enclosed)	:	
		e) Date of joining as freshentrant as per column No. 12 (Copy of reposting order asfresh entrant should be enclosed)	:	
13	Details of Regularization of Service as Assistant Surgeon, with Order number & date (Copy of order should be enclosed)		:	
14	Details of declaration of probation in the entry cadre		:	
	a)	Order No. & date (copy of order should be attached)	:	
	b)	Effective date of probation	:	
15	If not declared Probation in the cadre of Assistant Surgeon, furnish the reason		:	
16	Reason for representation		:	
17	Mobile Number		:	

Certified that the service particulars furnished above are true to the best of my knowledge and I understood that if any of the above furnished information are found incorrect in future, my seniority position will be liable to be reassigned and is shall lose all the service benefits acquired based on the incorrect information provided.

Dated Signature of Incumbent

Signature of Head of Institution

Counter signature of District Medical Officer of Health

Place:
Date: