केन्द्रीय विद्यालय संगठन/Kendriya Vidyalaya Sangathan
शिक्षा मंत्रालयभारत सरकार ,/Ministry of Education, Govt. of India
क्षेत्रीय कार्यालय /दिल्ली ,Regional Office, Delhi
पुराना जवाहर लाल नेहरू परिसरनया महरौली मार्ग ,
Old JNU Campus, New Mehrauli Marg
नई दिल्ली / New Delhi - 110067
दूरभाष सं/.Telephone No.: 7428551767
ई/.डी.मेल आई-E-Mail ID - aorodelhi1@gmail.com
वेबसाइट /Website - rodelhi.kvs.gov.in

EMPANALMENT OF DOCTORS WITH KENDRIYA VIDYALAYA SANGATHAN, REGIONAL OFFICE, DELHI FOR SERVING EMPLOYEES OF KENDRIYA VIDYALAYA'S UNDER DELHI REGION AS AUTHORIZED MEDICAL ATTENDANTS (AMAs)

Essential requirements:

1. **MBBS/MD/MS/DNB/BDS/MDS/BPT/MPT**
2. **Minimum Experience required: 2 years**

केन्द्रीय विद्यालय संगठन

केन्द्रीय विद्यालय संगठन
क्षेत्रीय कार्यालय, दिल्ली

PROFORMA TO BE FILLED BY DOCTORS RESIDING IN DELHI/NCR FOR EMPANELMENT WITH KENDRIYA VIDYALAYA SANGATHAN, REGIONAL OFFICE, DELHI AS AUTHORIZED MEDICAL ATTENDANT (AMA)

(You are requested to complete all the columns of this proforma to help in maintaining proper records)

To

The Deputy Commissioner
Kendriya Vidyalaya Sangathan,
Regional Office, Delhi

1. **Name of the intending Doctor:.....**
   (In Capital Letters)
2. **Cell Number of the Doctor:.....**
3. **Age:.....**
4. **Gender:.....**
5. **PAN Number:.....**
6. **Address (Residence):.....**

   .....
7. **Address (Clinic):.....**

   .....
8. **Clinic Days & Timings :.....**
9. **Details of Educational Qualifications: MD/MS/DNB/MBBS/ MDS/BDS/MPT/BPT (copies enclosed):.....**

   .....
10. **Year of Graduation:.....Post Graduation (Kindly, Specify) :.....**
11. **Specialization, if any (Kindly, Specify):.....**

12. **Total Experience: Government/Semi Government/Private (duration in years):.....**

13. **Whether ready to provide Consultation at CGHS rates ?: Yes/No**

14. **Average daily patient footfall (during last six months):.....**

15. **Whether the Doctor is attached to any Hospital ?:.....**

16. **Whether empanelled with any Govt. Organization? Yes/No.....**
If yes, attach the list:

17. **If empanelled with any Govt. organization, mention the name of the Organization & date of the empanelment: .....**
(Use separate sheet if space is not sufficient)

18. **Delhi Medical Council/Delhi Dental Council/Delhi Council of Physiotherapy and Occupational Therapy Registration No and Validity:**

.....

19. **Premises of the Clinic: rented/owned by self**
(Attach proof of premises of the clinic)

20. **Have you ever been convicted: Yes/No**

Signature of the Doctor

Place.....

Date.....