

Pakistan Agricultural Research Council

(Directorate of Logistics)

(Medical Section)

Plot No. 20, Ataturk Avenue, Sector G-5/1, Islamabad

Telephone: 051-90762301/41

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**APPLICATION FORM TO AVAIL MEDICAL FACILITY**

|  |  |
| --- | --- |
| **1.** | **EMPLOYEE DETAILS** |

EMPLOYEE ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PPO NO (*For retired only*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORKING STATUS: Serving Retired

IF RETIRED: Deceased Alive

EMPLOYMENT TYPE: Regular Contract Deputation-in

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DESIGNATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SPS:\_\_\_\_

CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POSTING:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HQ/CENTER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF APPOINTMENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXPIRY (*IF ANY*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RESIDENTIAL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE (OFF):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BLOOD GROUP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DISEASE(S), *IF ANY*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AMA (*if allotted*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
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| **2.** | **DEPENDENT DETAILS (ELDER TO YOUNGER)** |

*Eligible dependents to be entered only*

**Dependent-1**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent-2**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent-3**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent-4**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent-5**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent-6**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent-7**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent-8**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent-9**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent-10**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Group:\_\_\_\_\_\_ CNIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any disease(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **3.** | **EMERGENCY CONTACT PERSON** |

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MOBILE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **4.** | **SELF AND DEPENDENT PHOTOGRAPHS (To be pasted with gum and not stapled)** |

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

*-Please do not sign outside the box*

*-Please do not mention the date*

EMPLOYEE SIGNATURE

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paste Passport size (2 x 1.5)

[PHOTO]

-Recent

-Clear

|  |  |
| --- | --- |
| **5.** | **CERTIFICATE/UNDERTAKING** |

**I hereby certify that:**

1. The Dependents mentioned above are actually residing with me and fully dependent upon me as specified in the PARC employees (Medical Attendance & Treatment Regulations – 1990
2. The dependents mentioned above have no independent source of income.
3. The dependents mentioned above are not availing any medical facility from anywhere else.
4. In case of any change in dependency due to age/income/marriage or other factors, I will immediately convey such change in writing to the Medical Section, PARC.
5. If any discrepancy is found, I will be liable to return whole expenditure and liable to be proceeded under prevailing PARC Rules/Regulations.

**The above information is true and correct to the best of my knowledge and belief:**

**Signature with date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Designation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Certificate from the Head of Department/Officer Incharge of the Project/Unit**

Certified that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is working as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the Directorate/Project\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and particulars shown above to avail the medical facilities are correct to the best of my knowledge.

**Signature of the Head of Deptt./**

**Officer In charge & Stamp**

**DOCUMENTS REQUIRED (CHECKLIST)**

Please tick the checklist

|  |  |  |  |
| --- | --- | --- | --- |
| **S#** | **Required Documents** | **YES** | **NO** |
| 1 | Copy of Employee Card |  |  |
| 2 | Copy of CNIC (Self and Dependents) |  |  |
| 3 | Copy of Offer letter for appointment and Office Order |  |  |
| 4 | Copy of Pension Payment Order (If retired) |  |  |
| 5 | B-Form of Children below 18 years |  |  |
| 6 | Copy of Salary Slip (Last Month) |  |  |
| 7 | Copy of Nikah Nama/CNIC copy of wife having husband name on it |  |  |
| 8 | If any child is above 18 years and still studying, then enrolment record of relevant College/University etc. (Latest Fee slips) |  |  |
| 9 | Passport size picture for self and every dependent  |  |  |

(If not applicable, please write N/A.)

|  |  |
| --- | --- |
| **6.** | **FOR OFFICE USE ONLY** |

EMPLOYEE ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PPO NO (*For retired only*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DESIGNATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POSTING:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Remarks (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended By:

AUTHORIZED OFFICER

(with stamp)

Approved/Not approved:

AUTHORIZED OFFICER