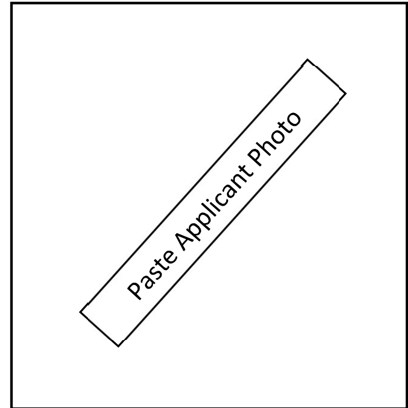
APPLICATION FORM FOR DOCTORS CORPUS FUND

Government Letter (Ms).No 200, dated: 22.04.2020 of
HEALTH AND FAMILY WELFARE (H) DEPARTMENT, CHENNAI-9
OFFICE: O/o Director of Medical & Rural Health Services, DMS Campus,
361, Anna Salai, Chennai – 600006.
E-Mail ID: dcf2020.dms@gmail.com



1. **Name (Initial at End)** :
2. **Gender** : **Male** ☐ **Female** ☐
3. **Date of Birth** :
4. **Date of Joining into service:**
5.
   a. **GPF No:** /
   b. **CPS No:** / **c.** N.A.
6. **TNMC Reg No:** **7. Aadhaar No:**
8. **Designation:**
9. **Office Address:**
10. **Permanent Address:**
11. **District:** **PIN Code:**
12. **Directorate:** **13. Mobile No:**
14. **E-Mail ID:**
15. **Nominee-1:** **Relationship:**
    Nominee-2: **Relationship:**
16. **Date of Option for the scheme & Subscription: Deduction in salary**

Date:

Place: **Signature of the Applicant**

DECLARATION:

I am willing to be enrolled in the Doctor’s Corpus Fund. I hereby declare that all the above said details are true to the best of my knowledge and ability. The subscription payable to the above scheme may be deducted as non-statuary deductions in my monthly salary. I also declare that I will abide by the rules & Regulations framed for Scheme of Doctors Corpus Fund from time to time and any suppression of facts will disqualify my nominee/legal heir from getting death financial assistance.

Date:

Place: **Signature of the Applicant**

Signature of DDO/Head of the Institution with Remarks

Note: Form should be prepared in duplicate and one to be retained at the institution, another submitted to Office of DCF at DM&RHS, Chennai.

Member Secretary **Chairman**