ARMED FORCES BONE MARROW TRANSPLANT CENTER RWP

Application form

Name (block letters)		
Father's Name		
CNIC No:	Date of Birth:	
Post Applied for:	Quota:	
Gender: Male ☐	Female ☐	
Home Address		
Mailing Address		
Telephone No.	Cell No.	Email:

Employment Record	Business Activity	Your Title & department	Period of employment

Education

Name and Place of institution	Year	Subjects	Qualifications	Grade/CGPA

Professional or other certification	Year

NOTE: Please enclose all required documents.

Incomplete forms will not be entertained

AFBMTC reserves the right to reject any candidate without assigning any reason.

DECLARATION

I hereby stand committed to the above information provided by me as true and accurate and agree to accept the term and conditions of this form.

Signature of applicant Date _____

051-9270076