



चित्तरंजन राष्ट्रीय कैंसर संस्थान
CHITTARANJAN NATIONAL CANCER INSTITUTE
(An Autonomous Institute under Ministry of Health and Family Welfare, Govt. of India)
(स्वास्थ्य और परिवार कल्याण मंत्रालय, भारत सरकार के अधीन एक स्वायत्त संस्थान)
प्रथम कैंपस - 37, एस. पी. मुखर्जी रोड, कोलकाता-700026/1st Campus - 37, S. P. Mukherjee
Road, Kolkata - 700 026
द्वितीय परिसर - स्ट्रीट नंबर 299, प्लॉट नंबर डीजे - 01, परिसर नंबर 02-0321, एक्शन एरिया
1डी, न्यू टाउन, कोलकाता - 700160
2nd Campus - Street No.299, Plot No. DJ - 01, Premises No. 02-0321, Action Area ID, New
Town, Kolkata - 700160

Affix Passport
Size Photograph

Reason for issuance -/Fresh Appointment /Renewal
/Change in Designation

Category of Employee-Regular ☐ Deputation ☐ Contractual ☐ Temporary ☐

Employee code :	
Name of Applicant (IN CAPITAL LETTERS) :	
Father's Name	
Designation :	
Department :	
Date of Joining/Renewing:	
Date of Birth :	
Blood Group :	
Pay Level :	
Mark of Identification :	
Corresponding (Present) Address :	Permanent Address :
In Case Emergency No :	Mobile No :
Email ID :	Applicant's Signature :
Forwarded by HOD (with Stamp) :	Issuing Authority:

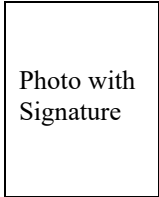
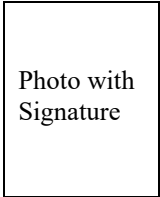
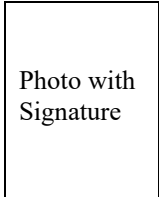
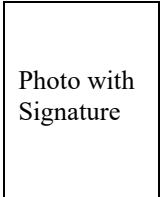
CHITTARANJAN NATIONAL CANCER INSTITUTE

37, S. P. Mukherjee Road, Kolkata- 700026

Proforma for Medical Identity Card.

1.	NAME (in capital letters)	:		Medical Identity Card No.:
2.	Designation	:		
3.	Date of Birth	:		
4.	Date of retirement	:		
5.	Residential address- i. Present Address:- ii. Permanent Address:-	:		(for office use only)
6.	Telephone / Mobile No.	:		 (Photo of the Employee with signature)
7.	Identification Mark	:		
8.	Blood group	:		
9.	Basic Pay as on			

Details of Eligible Dependent Family Members of Employee :-

 Name: Relationship: D.O.B. Blood Group Occupation* Signature / L.T.I. :	 Name: Relationship: D.O.B. Blood Group Occupation* Signature / L.T.I. :
 Name: Relationship: D.O.B. Blood Group Occupation* Signature / L.T.I. :	 Name: Relationship: D.O.B. Blood Group Occupation* Signature / L.T.I. :

* Enclose copy of Adhar Card & Pan Card (self attested) of dependent family members, along with last pay slip in case of Working Person.

Signature of EmployeeSignature of Head of Office



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UNDERTAKING FOR MEDICAL FACILITY

1. Name & Designation of Employee _____
2. Residential Address _____
3. Details of Family as on _____

Sl.No.	Name	Age (DOB)	Relationship	Remarks
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

I hereby declare that:-

1. My father/mother/parent namely _____

_____ is/are wholly/solely dependent on me and their income limit is Rs. 9000/- + D.R. per month.

2. My son/daughter _____

_____ aged

_____ years is unemployed and wholly dependent on me.

3. My wife/husband is employed in _____

_____ (Complete name & address of the office)

He/she has undertaken not to avail of the medical facilities provided by the said organization and a No Objection Certificate (NOC) to that effect through his/her employer is attached.

The above information is given to the best of my knowledge and belief. I am aware that in case of any information is found false at any point of view I can be prosecuted under CCS (CCA) Rules 1965 amended from time to time.

***Strike out the column(s) which is/are not applicable.**

(Signature of the Employee)