BAHRIA UNIVERSITY HEALTH SCIENCES CAMPUS KARACHI (BUHSCK)

BAHRIA UNIVERSITY MEDICAL COLLEGE (BUMC)

&

BAHRIA UNIVERSITY DENTAL COLLEGE (BUDC)

FCPS RESIDENCYPROGRAM APPLICATION FORM

Paste photograph here

Applied for: Medical / Dental Residency Program: _____

Department / Speciality: _____

Sub-speciality:_____

Required Residency period :(Please tick one) 2 years / 3years / 4 years / 5 years

1. PERSONAL INFORMATION:

Name: _____ Father's Name: _____

CNIC #:_____ Date of Birth: _____ Marital Status: _____

Tele / Cell #: _____ Email:_____

Nationality: _____ Postal Address:_____

_____

PMC Registration No: _____Valid upto: _____

2. QUALIFICATION (Starting from the Highest Qualification):

Degree / Certificate	Duration in Years	Passing Year	% age / Grade	Institute / Board / University

3. EXPERIENCE (teaching / field):

Position / Job Title	Institution / Organization	Period		Total Period
		From	To	

4.ADDITIONAL INFORMATION:

A) MBBS / BDS passing year:_____

B) FCPS part-1 passing year: _____

C) Currently working / on Job: Yes / No: _____

If yes specify: Working hospital / College / Any other_____

_____

D) Doing FCPS residency: Yes / No: _____

If yes specify: Year of residency/ Name of Hospital /College / University: _____

_____

_____

E) Number of published papers:_____

F) Journals approved by PMC/ HEC/ Both:_____

G) National/ International Journals:_____

H) Impact factor: _____

Name of candidate: _____

Signature of candidate: _____

Date: _____