

PROFESSIONAL EXPERIENCES				
SPECIALTY	INSTITUTION	TO DD/MM/YY	FROM DD/MM/YY	DURATION

SURGICAL EXPERIENCES			
NAME OF SURGERY	NUMBER DONE	DONE INDEPENDENTLY	DONE WITH ASSISTANCE

FUNDING & PAYMENTS	
Please indicate your intended source of funding below with a tick mark.	
SELF-FINANCED	SPONSORED
Sponsor's Details	
NAME OF THE ORGANIZATION	
NAME OF THE CONTACT PERSON	
CONTACT NUMBER	
Please indicate your method of payment below with a tick mark.	
CASH	DD
	WIRE TRANSFER

DECLARATION

I HEREBY DECLARE THAT ALL THE INFORMATION PROVIDED IN THIS APPLICATION AND THE SUPPORTING DOCUMENTS ARE CORRECT, TRUE AND COMPLETE.

DATE:

SIGNATURE OF THE APPLICANT

PLEASE ENCLOSE:

- Academic Certificates
- BMDC Registration
- National Identity Card (NID)
- Certificates of Experiences/ Surgical / Clinical Training (if any)
- No objection certificate from the head of present organization (if employed)

Please scan this application form (duly filled in) and required documents and send the scanned copies to: dico.decf@gmail.com or by post to the following address: Executive Director, Deep Eye Care Foundation, Darshona, Akkelpur, Rangpur.