

WAPDA HOSPITAL COMPLEX, LAHORE

EMPLOYEE'S REGISTRATION FORM - A

Version. 12
Revised On. 17-05-2004

Photograph

1. Company / Department Name

2. Employee Identification Code	
2-A. New N.I.C. No.	2-B. Old N.I.C. No. (If new NIC is not issued)
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3. Employee Name

4. BPS	5. Code	5-A. Designation Description

6. Father's / Husband's Name

7. Gender	
Male	Female

8. Date of Birth			
-	-		

9. Book No. (if any)			

10. Marital Status	
Single	Married

11. Family Size	

12. Blood Group		

13. Medical Facility	
MF	CMA

14. Registration Type	

15. WAPDA joining Date			
-	-		

16. Current Posting Date			
-	-		

17. Office Code	17-A. Present Office Name, Address and Telephone No.

18. Present Home Address	18-A. Telephone(s)

19. Permanent Home Address	19-A. Telephone(s)

TO BE FILLED BY THE WAPDA HOSPITAL

The employee whose particulars are given in **Form-A** and **Form-B** is hereby allowed Medical Facilities in accordance with WAPDA Medical Attendance Rules.

Date

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Signature Officer Incharge (Hospital)

Please read instructions before fill the Form-A and Form-B.

WAPDA HOSPITAL COMPLEX, LAHORE

INSTRUCTIONS TO FILL EMPLOYEE'S AND DEPENDENT'S REGISTRATION FORM

1. Please fill the form in Capital Letters
2. Write NA if not applicable in any column
3. In case of any change, this form must be filled and sent to the WAPDA Hospital complex, Lahore through relevant office.
4. Please supply three color Photographs of Employee.
5. In case of Retired / Widows, the Form-A and Form-B can be attested by the Pension Disbursement Officer.
6. Use Additional Sheet if Required for Form-B.

FORM-A

Col: #	Description / Instruction	Remarks
1	Employee's Company / Department Name	Must be Filled
2-A	Employee's New National Identity Card Number	Must be Filled
2-B	Employee's Old National Identity Card Number	Must be Filled
3	Name of Employee	Must be Filled
4	Basic Pay Scale i.e. 01,02,03,.....22	Must be Filled
5	Designation Code	For office use
5-A	Designation of Employee	Must be Filled
6	Father's / Husband Name of Employee	Must be Filled
7	Gender (Male / Female)	Must Tick any
8	Date of Birth of Employee (DD-MM-YYYY) i.e. 01-01-1960	Must be Filled
9	WAPDA Medical Treatment Book Number	If any
10	Marital Status i.e. Single / Married	Must Tick any
11	Size of Family i.e. Self + All Dependents.	Must be Filled
12	Blood Group i.e. A+, AB+ etc.	Must be Filled
13	Medical Facility you are availing	Must Tick any
14	Registration Type i.e. Regular, Retired, Widow, Contract, Deputation, Outstation, Others	Must be Filled
15	WAPDA Joining Date (DD-MM-YYYY)	Must be Filled
16	Current Posting Date (DD-MM-YYYY)	Must be Filled
17	Office Code	For office use
17-A	Present office Name, Address and Telephone No.	Must be Filled
18	Present Home Address	Must be Filled
18-A	Present Home Telephone Number with City Code i.e. 042-9202211	If any
19	Permanent Home Address	Must be Filled
19-A	Permanent Home Telephone Number with City Code	If any

FORM-B

Col: #	Description / Instruction	Remarks
1	Employee's Company / Department Name	Must be Filled
2-A	Employee's New National Identity Card Number	Must be Filled
2-B	Employee's Old National Identity Card Number	Must be Filled
3	Dependant's Name	Must be Filled
3-A	Dependant's Father's / Husband Name	Must be Filled
4	Relationship with Employee i.e. Wife, Husband, Son, Daughter etc.	Must be Filled
5	Gender of the Dependant (s)	Must be Filled
6	Date of Birth (DD-MM-YYYY)	Must be Filled
6-A	National Identity Card No	If any

Date: _____

Employee Signature