



## Application Form

### ARMED FORCES INSTITUTE OF PATHOLOGY

Name (block letters)	
Father's Name	
CNIC No:	Date of Birth:
Post Applied for:-	Station:
<b>Mailing Address:</b>	
<b>Age</b>	
Telephone	Mobile No.
E-mail:	

#### **For Government Servant:-**

NOC Obtained	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Please attached copy of NOC				

#### **EDUCATION**

Name and Place of Institution	Year	Subject	Qualifications

<b><u>Experience / Course Certification if any</u></b>	Year

**NOTE:** Please enclose all required documents.  
Incomplete form will not be entertained  
AFIP Rwp reverses 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 terms and conditions of this form.

Signature of applicant

Date \_\_\_\_\_