



**BAHRIA UNIVERSITY HEALTH SCIENCES CAMPUS**

**KARACHI (BUHSCK)**

**BAHRIA UNIVERSITY MEDICAL COLLEGE (BUMC)**

**&**

**BAHRIA UNIVERSITY DENTAL COLLEGE (BUDC)**

**FCPS RESIDENCY PROGRAM APPLICATION FORM**

Applied for: Medical / Dental Residency Program: \_\_\_\_\_

Department / Speciality: \_\_\_\_\_

Sub-speciality: \_\_\_\_\_

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

Paste photograph  
here

**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: \_\_\_\_\_