



## APPLICATION FORM FOR ADMISSION FCPS in Health Professions Education

### PERSONAL DATA

PLEASE FILL ALL FIELDS IN CAPITAL LETTERS IN OWN HANDWRITING

|                               |   |   |   |   |  |  |   |
|-------------------------------|---|---|---|---|--|--|---|
| <b>Full Name</b>              |   |   |   |   | <div style="border: 1px solid black; padding: 5px; width: 80%; margin: auto;">PASTE COLOR PHOTOGRAPH</div> |  |   |
| <b>Father's Name</b>          |   |   |   |   |  |  |   |
| <b>Gender</b>                 | Male <input type="checkbox"/>                 | Female <input type="checkbox"/>           | <b>Nationality</b>                              |   |  |  |   |
| <b>Date of Birth</b>          | Day <input style="width: 20px;" type="text"/> | <input style="width: 20px;" type="text"/> | Month <input style="width: 20px;" type="text"/> | <input style="width: 20px;" type="text"/> |  | Year <input style="width: 20px;" type="text"/> | <input style="width: 20px;" type="text"/> |
| <b>CNIC No</b>                | <input style="width: 20px;" type="text"/>     | <input style="width: 20px;" type="text"/> | <input style="width: 20px;" type="text"/>       | <input style="width: 20px;" type="text"/> |  | <input style="width: 20px;" type="text"/>      | <input style="width: 20px;" type="text"/> |
| <b>Mailing Address (Res.)</b> |   |   |   |   |  |  |   |

|                       |  |                |  |
|-----------------------|--|----------------|--|
| <b>E-Mail Address</b> |  |                |  |
| <b>Tel No</b>         |  | <b>Cell No</b> |  |

**Current Health Status** (In order to identify any specific assistance that you may require for the facilitation on account of your personal health)

- Any Medical /Surgical /Psychiatric illness /disability that could impede/limit your performance during the course: \_\_\_\_\_
- Any consequent special assistance needed: \_\_\_\_\_

### EMPLOYMENT INFORMATION (Current Position)

|   |  |                        |  |
|---|--|------------------------|--|
| <b>Designation</b>                          |  |                        |  |
| <b>Institution/ Organization</b>            |  | <b>Date of Joining</b> |  |
| <b>Address</b>                              |  |                        |  |
| <b>Tel No</b>                               |  |                        |  |
| <b>Current Job Responsibilities (Brief)</b> |  |                        |  |

**EMPLOYMENT EXPERIENCE (starting from the last)**

| Designation, Name of Institution, Place | FROM  |      | TO    |      | Duration |
|---|-------|------|-------|------|----------|
|   | Month | Year | Month | Year |          |
|   |       |      |       |      |          |
|   |       |      |       |      |          |
|   |       |      |       |      |          |
|   |       |      |       |      |          |
|   |       |      |       |      |          |
|   |       |      |       |      |          |
|   |       |      |       |      |          |

| Teaching Positions held | Month | Year | Month | Year | Duration |
|-------------------------|-------|------|-------|------|----------|
|                         |       |      |       |      |          |
|                         |       |      |       |      |          |
|                         |       |      |       |      |          |
|                         |       |      |       |      |          |
|                         |       |      |       |      |          |
|                         |       |      |       |      |          |
|                         |       |      |       |      |          |
|                         |       |      |       |      |          |

| Educational Courses/ Workshops Attended<br>(attach attested photocopy) | Month | Year | Month | Year | Duration |
|--|-------|------|-------|------|----------|
|  |       |      |       |      |          |
|  |       |      |       |      |          |
|  |       |      |       |      |          |
|  |       |      |       |      |          |
|  |       |      |       |      |          |
|  |       |      |       |      |          |

| Any other academic program enrolled currently<br>(Permission letter to pursue FCPS from in-charge of the program) | Month | Year | Month | Year | Duration |
|---|-------|------|-------|------|----------|
|   |       |      |       |      |          |
|   |       |      |       |      |          |
|   |       |      |       |      |          |
|   |       |      |       |      |          |
|   |       |      |       |      |          |



## UNDERTAKING

I have carefully read the instructions and testify that all the information provided is complete and correct. I understand that withholding any information or providing false information shall make me ineligible for admission to this Program.

**Note:** Incomplete applications will not be entertained.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

## DOCUMENTS ATTACHED (Please Tick)

- For issuance of the FCPS-HPE bank challan of Rs. 5000/-, kindly visit the CPSP Headquarter or the respective Regional Center. (non-refundable)
- Experience certificates from the Institutions
- Reasons for your interest in FCPS-HPE course
- Submission of a thesis proposal/synopsis aligned with FCPS-HPE research requirements
- At least two (02) medical Education related publications in CPSP-approved journals with in the last five years
- Attested Photocopy MCPS-HPE/MHPE degree
- Attested Photocopy Postgraduate degree (if any)
- Attested Photocopy Valid PMDC Certificate
- Attested Photocopy Computerized National Identity Card
- Attested Photocopy Experience Certificate from the Institutions

**Note:**

The hard copies will not be accepted. Kindly email all scanned copies with paid challan to the email: [fcpshe@csp.edu.pk](mailto:fcpshe@csp.edu.pk).

POSTAL ADDRESS:

Directorate of Medical Education,  
College of Physicians & Surgeons Pakistan,  
7th Central Street, D.H.A, Phase-II, Karachi.— 75500.

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