Human Resource Management Information System (HRMIS) for Grade Dental Surgeons

Data Collection Form

Personal Details

NIC*

Initials *

Last name*

Names Denoted by Initials*

Maiden Name

Date of Birth* Y Y Y Y M M D D

Gender* Male Female

Marital Status* Single Married Divorced Widowed Legally Separated Other

If married NIC of Spouse

Permanent Residential Address*

Line 1
Line 2
Town / City
District

Contact Details*

Mobile No.1
Mobile No.2
Land Line No.
E Mail

University, granted the Basic Dental Degree

Name of the Degree* **Year** Y Y Y Y

Name of the Degree (MBBS / MD/BDS)

For foreign graduates, state date of completion of ACT-16/SLMC Examination Y Y Y Y M M D D

Ethnicity **Religion**

SLMC No.* **W & OP No.**

Taken Vehicle Permit? Yes No **Issued date of the most recent Vehicle Permit** Y Y Y Y M M D D

Paying Authority* **Pay roll No.***

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Grade Details

Grade Details*												
Grade Details*	First Appointment	Y	Y	Y	Y	M	M	D	D	Formal App. Letter Available?	Yes	No
	Grade II Confirmation	Y	Y	Y	Y	M	M	D	D	PSC approved GII Letter Received?	Yes	No
	Grade I	Y	Y	Y	Y	M	M	D	D	PSC approved GI Letter Received?	Yes	No
Confirmation Details*	Date of Confirmation	Y	Y	Y	Y	M	M	D	D	Confirmation Letter Available?	Yes	No

If Probation period extended									
If Probation period extended	From	Y	Y	Y	Y	M	M	D	D
	To	Y	Y	Y	Y	M	M	D	D
	Duration in Days								
	Reasons								

No-Pay Details*

Note: No pay reasons; Overseas leave/ medical leave/ extended maternity leave **except** ordinary maternity no pay leave

	Reason	Commenced Date								End Date							
1st		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
2nd		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
3rd		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D

Disciplinary Inquiries*

	Reason	Action Taken (According to the PSC order)	Does it affect the Seniority?	Time Period															
			Y / N	From								To							
1st				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
2nd				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
3rd				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D

Post Graduate Training Attachments*

Course Type Dip./MSc/MD	Name of the Course	Date released to PGIM								Date that Course started								Released date from PGIM								Course Completed?	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	N
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	N
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	N

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Appointment and Transfer Details

Sequence	Transfer/ Appointment type**	Institution Name	Post (As of Appointment / Transfer List)	Appointment /Transfer date as of list or letter								Duty reported date to the Institution								Released date from the Institution								Remarks
1				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
2				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	

*Mandatory fields

** Transfer/ Appointment type: First Appointment, Annual, Special appeal, Special post, Seconded post, North and East List, Temporary Transfers, PGIM Attachment.

If transfer type is a temporary attachment please mention whether it is a Post PGIM , Post No pay, Punishment, Reinstatement or special reasons.(for special reasons mention it in the remarks cage)

At least 1st Appointment and Current Appointment should be filled.

Declaration

I certify that the above mentioned particulars are true and correct. I am aware that I shall be punished if incorrect information has been submitted.

………………………………………… ……………………………………………
Date Signature of Doctor

I declare that the above particulars submitted by the medical officer are compatible with his / her personal record.

………………………………………… ………………………………………………………….. ……………………………………………
Date Name of HMA Signature of HMA

……………………………………………..
Contact No. of HMA

Observation and Recommendation of the Head of Institution / Decentralised Unit / Specialised Campaign/ Regional Director of Health Services/ Provincial Director of Health Services;
I certify the particulars furnished by the medical officer, are correct.

………………………………………… ……………………………………………
Date Signature of Head of Institution