



OFFICE OF THE CHIEF DISTRICT MEDICAL & PUBLIC HEALTH OFFICER  
CUM DISTRICT MISSION DIRECTOR, NHM, NUAPADA  
NUAPADA, ODISHA, 766105



E-mail : cdmocumdmduapada@gmail.com

Phone: (06678)-225908

Letter No: 2643 / DPMU/NHM/2020

Date: 9/8/2020

NOTICE

In partial modification of the Order no 2609/DPMU/NHM/20 dated 07.08.2020 of CDM & PHO, Nuapada regarding joining and counseling for the post of MPHWF for COVID Care Home, all candidates are informed to submit a Declaration Form in prescribed format attached here with in place of an undertaking uploaded as Annexure C

  
CDM & PHO cum DMD  
Nuapada



ANNEXURE - C

DECLARATION FORM

Name of the Candidate:

Father/Husband name:

Address: At: \_\_\_\_\_ PO \_\_\_\_\_ PS \_\_\_\_\_ Dist \_\_\_\_\_

Age: \_\_\_\_\_ yrs \_\_\_\_\_ months

Sl. No in the Merit list : \_\_\_\_\_.

Marital Status: Married / Unmarried

I do hereby declare that the following status for information and necessary future reference.

- i. If Married – Are you pregnant (Yes/No) \_\_\_\_\_.
- ii. If Yes: EDD \_\_\_\_\_ . ( Attach a copy of MCP Card/ Prescription from doctor)
- iii. Co- morbid conditions for COVID 19
  - a. Cancer – Yes/No
  - b. Chronic Kidney diseases – Yes/No
  - c. Diabetecs – Yes/No
  - d. Hypertension – Yes/No
  - e. Cardiovascular diseases – yes/No
  - f. Tuberculosis – Yes/No
  - g. Have you suffered from Malaria in last one month – Yes/No
  - h. Do you have Asthma – Yes/No
  - i. Are you suffer from Sickle cell Disease – Yes/No
  - j. Any other disease – Please mention \_\_\_\_\_

I do hereby declare that the information furnished above are true to the best of my knowledge and belief and that, if at any stage, it is found that any of the above information given above is false/incorrect or is suppressed by me, I will be held responsible and I will not claim any compensation in any form to the govt.

Date: \_\_\_\_\_

Place \_\_\_\_\_

Full Signature of the Candidates