

THE TAMIL NADU Dr. M.G.R. MEDICAL UNIVERSITY CHENNAI – 600 032

DATA ENTRY FORM FOR FACULTY MANAGEMENT SYSTEM

Name of the Faculty :
Initials: Gender : Male/ Female
Date of Birth :
Father's Name :
Nationality :
PAN No :

Council Registration Details:

Council Name :
Council State :
Reg.No :

Contact Details :

Permanent Address :

State : District :

Present Address :

State : District :

Phone No (with STD Code :

Mobile No :

Faculty's E-Mail ID :

PAN Card No. :

Aadhar No, :

Experience Details

Experience Type	Institution	University	Experience from Date: (DD-MMYYYY)	Experience to Date: (DD-MMYYYY)	Experience (Yrs/Times)

Remarks (if Any):

Signature