



## Health Department, GoB

### Health Employee Data Collection Form

This is a paper form used to collect data from the health employee (both permanent and contractual) of the State Government. It can be printed and copied for use. The purpose of collecting data in this paper form is to establish a Human Resources Information System (HRIS) for health and use it to provide better support to the health employees and improve effectiveness of health programmes in the State. Kindly ensure that information shared in this form is correct.

<b>SECTION I: EMPLOYEE DETAILS</b>			
<b>A. Personal Details:</b>			
<b>Title (Mr./ Ms/ Mrs. / Dr.):</b>	<b>First Name:</b>	<b>Middle Name:</b>	<b>Surname:</b>
<b>Seniority Number</b> (For Regular Employee Only) :		<b>GPF/CPF No.</b> (For Regular Employee Only):	
<b>Year:</b>			
<b>Nationality</b> (specify):			
<b>Date of Birth (dd/mm/yyyy):</b>		<b>Gender (check one box):</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	
<b>Handicap:</b> (check one box): <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Marital Status (check one box):</b> <input type="checkbox"/> Single <input type="checkbox"/> Married		<b>Number of Dependents (Govt. approved):</b>	
<b>Blood Group</b> (specify):		<b>Identification Mark</b> (specify)::	
<b>Category (check one box):</b> <input type="checkbox"/> General <input type="checkbox"/> BC <input type="checkbox"/> EBC <input type="checkbox"/> SC <input type="checkbox"/> ST <input type="checkbox"/> Other (specify)			
<b>B. Permanent Residence:</b>			
<b>Village/Mohalla-</b>		<b>Thana-</b>	
<b>Block-</b>		<b>District-</b>	
<b>State-</b>		<b>PIN Code :</b>	
<b>C. Guardian Details</b>			
<b>Father's Full Name (First, Middle, Surname):</b>			
<b>Mother's Full Name (First, Middle, Surname):</b>			
<b>Husband's/Wife's Full Name (First, Middle, Surname):</b>			
<b>Is your husband/wife a regular employee of Bihar Government? (check one box):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If your husband/wife is a regular employee of Bihar Government, please mention the name of Current Posting facility/department (with block and district):</b>			
<b>Is he/she a regular doctor? (check one box):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>D. Work Contact Details</b>			
<b>Postal Address for Correspondence :</b>			
<b>Office Phone (Landline with STD Code):</b>			<b>Fax No.:</b>
<b>Mobile phone No (Self):</b>		<b>Email Id (Self-If any.):</b>	
<b>E. Identification (check one box; For Contractual Employee Only)</b>			
<input type="checkbox"/> Driving License License No.	<input type="checkbox"/> Voter ID Card ID Card No.	<input type="checkbox"/> Ration Card Ration Card No.	<input type="checkbox"/> Other ( please specify): Id. No.

F. Nominee Details (For Regular Employee Only)	
Full Name (First, Middle, Surname):	Date of Birth (dd/mm/yyyy):
Relationship (check one box): <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Others (please specify)	

SECTION 2: POSITION INFORMATION		
Current Designation		
Current Posting Date (dd/mm/yyyy):	Current Salary:	Current Pay Scale/ Grade Pay (specify):
Government Order Details	Order Date (dd/mm/yyyy):	Order No.:
	Order Issuing Dept/Unit Name:	
Current Posting Dept. /Unit/Facility Name (Including Block & District)		
<b>Current Posting Dept. / Unit/ Facility Type (check one box)</b> <input type="checkbox"/> HSC <input type="checkbox"/> APHC <input type="checkbox"/> PHC <input type="checkbox"/> RH <input type="checkbox"/> FRU <input type="checkbox"/> Sub-Divisional Hospital <input type="checkbox"/> District Hospital <input type="checkbox"/> CS Office <input type="checkbox"/> DHS <input type="checkbox"/> RMPU <input type="checkbox"/> RDD Office <input type="checkbox"/> Medical College & Hospital <input type="checkbox"/> SHSB <input type="checkbox"/> Health Deptt. (Secretariat) <input type="checkbox"/> Directorate of Health <input type="checkbox"/> Directorate of Ayush <input type="checkbox"/> Medical Education <input type="checkbox"/> Other (specify):		
Designation Grade (check one box)	<input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV <input type="checkbox"/> Grade V	
Nature of Employment ( check one box): <input type="checkbox"/> Regular Staff <input type="checkbox"/> Contract Staff		
Appointment Details - For Regular Employee (as applicable):		
Ad-hoc Appointment Date (dd/mm/yyyy): Regular Appointment/Regularisation Date (dd/mm/yyyy): Designation on Appointment: Appointment Confirmation Date (dd/mm/yyyy): Appointment Confirmation Order Number & Date (dd/mm/yyyy):		
SECTION 3: DEPUTATION INFORMATION (For Regular Employee Only)		
Are you on deputation to the current health facility/department? (check one box) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the following information:		
Government Order Details	Date (dd/mm/yyyy):	Order No.:
	Order Issuing Government Dept/Unit Name:	
Name of Dept./Unit/Facility Deputed From (including block and district):		
Deputation Date (dd/mm/yyyy):		
Designation (at the Dept./Unit/Facility Deputed From):		
Dept./Unit/Facility (Deputed From) Type (check one box) : <input type="checkbox"/> HSC <input type="checkbox"/> APHC <input type="checkbox"/> PHC <input type="checkbox"/> RH <input type="checkbox"/> FRU <input type="checkbox"/> Sub-Divisional Hospital <input type="checkbox"/> District Hospital <input type="checkbox"/> CS Office <input type="checkbox"/> DHS <input type="checkbox"/> RMPU <input type="checkbox"/> RDD Office <input type="checkbox"/> Medical College & Hospital <input type="checkbox"/> SHSB <input type="checkbox"/> Health Deptt. (Secretariat) <input type="checkbox"/> Directorate of Health <input type="checkbox"/> Directorate of Ayush <input type="checkbox"/> Medical Education <input type="checkbox"/> Other (specify):		

**SECTION 4: POSTING & PROMOTION DETAILS (For Regular Employee Only)**

Please start with **FIRST POSTING** and mention **Till Date**. Kindly also include period under '**Waiting for Posting**', '**Leave/Absence**' & '**Suspension**' and write '**Waiting for Posting**', '**Leave/Absence**' or '**Suspension**' in the **Posting Facility/Department** column if applicable.

Sl. No.	From Date (dd/mm/yyyy)	To Date (dd/mm/yyyy)	Posting Dept./Unit/ Name & Type (e.g. Rampur PHC)	Posting Block & District	Designation	Government Order No. & Date (dd/mm/yyyy)	Reason for Change (select one option: Transfer/Promotion/ Promotion & Transfer/Deputation/ None)

SECTION 5: EDUCATIONAL DETAILS					
Qualification/ Speciality	Write/Check	Institute Name	Board/University Name	Institute Address (including district, state and country name)	Completion Year
<b>Highest Educational Qualification</b>	<b>Check one box:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Middle <input type="checkbox"/> High School <input type="checkbox"/> Intermediate (10+2) <input type="checkbox"/> Diploma <input type="checkbox"/> Post Graduate Diploma <input type="checkbox"/> Graduate <input type="checkbox"/> Post Graduate <input type="checkbox"/> Ph.D. <input type="checkbox"/> No Formal Education <input type="checkbox"/> Other (specify)				
<b>Highest Professional Qualification</b> [Please enclose copy of certificate/ degree]	<b>Check appropriate box (es):</b> <input type="checkbox"/> MBBS <input type="checkbox"/> MD <input type="checkbox"/> MS <input type="checkbox"/> DM <input type="checkbox"/> MCH <input type="checkbox"/> BAMS <input type="checkbox"/> BHMS <input type="checkbox"/> BUMS <input type="checkbox"/> MSc Nursing <input type="checkbox"/> BSc Nursing <input type="checkbox"/> GNM <input type="checkbox"/> ANM <input type="checkbox"/> LLB <input type="checkbox"/> LLM <input type="checkbox"/> B.Tech <input type="checkbox"/> M.Tech <input type="checkbox"/> MBA <input type="checkbox"/> MCA <input type="checkbox"/> CA <input type="checkbox"/> Other (specify)				
<b>Speciality</b> [for doctors and nurses only; Please enclose copy of certificate/ degree]	<b>Write Speciality Name (s):</b>				

**Declaration:** I certify that the information provided in this form is true to the best of my knowledge.

**Date:**

**Signature:**

**Place:**

**Name:**