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.

SECTION 1: EMPLOYEE DETAILS

A. Personal Details:

Title (Mr./Ms/Mrs./Dr./Er./Miss)**:**	**First Name:**	**Middle Name:**	**Surname:**
Seniority Number (For Regular Employee Only) : **Year:**		**GPF/CPF No.** (For Regular Employee Only):	
Nationality(specify):			
Date of Birth *(dd/mm/yyyy)*:		**Gender** (check *one* box): ☐ Female ☐ Male ☐ Transand	
Handicap: (check *one* box): ☐Yes ☐No			
Marital Status (check *one* box): ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Widower		**Number of Dependents (Govt. approved):**	
Blood Group(specify):		**Identification Mark(specify):**	
Category (check *one* box): ☐ General ☐BC ☐EBC ☐SC ☐ST			
Religion (check *one* box): **-** ☐ Buddhism ☐Christianity ☐Hinduism ☐ Jainism ☐ Muslim ☐ Sikhism			

B. Permanent Residence:

Village/Mohalla-	**Thana-**
District-	**State-**
PIN Code :	

C. Guardian Details

Father's Full Name (First, Middle, Surname):

Mother's Full Name (First, Middle, Surname):

Husband's/Wife's Full Name (First, Middle, Surname):

Is your husband/wife a regular employee of Bihar Government? (check *one* box): ☐ Yes ☐ No
If your husband/wife is a regular employee of Bihar Government, please mention the name of Current Posting facility/department (with block and district):

Is he/she a regular doctor? (check *one* box): ☐ Yes ☐ No

D. Work Contact Details				
Postal Address for Correspondence :				
Office Phone (Landline with STD Code):			**Fax No.:**	
Mobile phone No (Self):		**Email Id (Self-If any.):**		
E. Identification (check *one* box; For Contractual Employee Only)				
☐ Driving License License No.	☐ Voter ID Card ID Card No.	☐ Ration Card Ration Card No.	☐ Other (please specify): Id. No.	☐ Aadhar Card ID Card No.
F. Nominee Details (For Regular Employee Only)				
Full Name (First, Middle, Surname):			**Date of Birth** *(dd/mm/yyyy)*:	
Relationship (check *one* box): ☐ Father ☐ Mother ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Others (please specify)				

SECTION 2: POSITION INFORMATION			
Current Designation			
Current Posting Date *(dd/mm/yyyy):*	**Current Salary:**	**Current Grade Pay:**	**Current Pay Scale:**
Government Order Details	Order Date (dd/mm/yyyy):	Order No.:	
	Order Issuing Dept/Unit Name:		
Current Posting Dept. /Unit/Facility Name (Including Block & District)			
Current Posting Dept. / Unit/ Facility Type (check *one* box) ☐ HSC ☐ APHC ☐ PHC ☐ RH ☐FRU ☐ Sub-Divisional Hospital ☐ District Hospital ☐ CS Office ☐ DHS ☐ RMPU ☐ RDD Office ☐ Medical College & Hospital ☐ SHSB ☐ Health Deptt. (Secretariat) ☐Directorate of Health ☐ Directorate of Ayush ☐ Medical Education ☐ Other (specify):			
Designation Grade (check *one* box)	☐ Grade I ☐ Grade II ☐ Grade III ☐ Grade IV ☐ Grade V		
Nature of Employment (Check one box):	☐ Regular Staff ☐ Contract Staff ☐ Tenure		
☐ Additional Charge			
Additional Charge Designation:	Additional Charge Start Date:	Additional Charge Facility:	

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):

Original Appointment Letter ☐ Yes ☐No	Original Appointment Letter Attached ☐ Yes ☐No	Who has verified it:

SECTION 3: DEPUTATION INFORMATION (For Regular Employee Only)

Are you on deputation to the current health facility/department? (check *one* box) ☐ Yes ☐No
If Yes, please provide the following information:

Government Order Details:

Original Appointment Letter ☐ Yes ☐No		Original Appointment Letter Attached ☐ Yes ☐No
Who has verified it:	Order No.:	Date (dd/mm/yyyy):

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) :☐ HSC ☐ APHC ☐ PHC ☐ RH ☐ FRU ☐ Sub-Divisional Hospital ☐ District Hospital ☐ CS Office ☐ DHS ☐ RMPU ☐ RDD Office ☐ Medical College & Hospital ☐ SHSB ☐ Health Dept. (Secretariat) ☐ Directorate of Health ☐ Directorate of Ayush ☐ Medical Education ☐ 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**
Highest Educational Qualification	**Check *one* box:** ☐ Primary ☐ Middle ☐ High School ☐ Intermediate (10+2) ☐ Diploma ☐ Post Graduate Diploma ☐ Graduate ☐ Post Graduate ☐ Ph.D. ☐ No Formal Education ☐ Other (specify)				
Highest Professional Qualification [Please enclose copy of certificate/ degree]	**Check *appropriate* box (es):** ☐ MBBS ☐ MD ☐ MS ☐ DM ☐ MCH ☐ BAMS ☐ BHMS ☐ BUMS ☐ MSc Nursing ☐ BSc Nursing ☐ GNM ☐ ANM ☐ LLB ☐ LLM ☐ B.Tech ☐ M.Tech ☐ MBA ☐ MCA ☐ CA ☐ Other (specify)				
Speciality [for doctors and nurses only; Please enclose copy of certificate/ degree]	**Write Speciality Name (s):**				

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

Date: **Signature:**

Place: **Name:**