



**SOUTHERN RAILWAY**

Application Reg.No

Application Serial No

Application Form for engagement of Act /Trade Apprentice under the Apprentices Act.1961

(Note: Please read the instructions carefully before filling up the application)

Application for EX.ITI  
(Tick Mark)

Application for Fresher  
(Tick Mark)

Paste recent passport size photo (3.5cmX3.5cm) not earlier than 3 months from the date of application with clear front view without cap and sunglass  
**Should be attested by Gazetted officer**

1	Name (in Block letter) (As in Matriculation certificate)	
2	Name of Father/Mother/Husband (As in Matriculation certificate)	
3	Full Postal Address (in block letters)	District: State : Pin code: Mobile No :
4	Aadhaar No (Proof to be enclosed)	
5	Gender (Male /Female)	
6	Date of birth(in Christian era) & Age as applying	/
7	Religion (Hindu/Muslim/Christian/others)	
8	Community : General/OBC/SC/ST (Attached certificate in case of OBC/SC/ST) OBCCertificate should not be older than one year from the date of closure ofthe Employment Notice with contain Non creamy layer clause)	
9	Whether Physically Challenged(Yes/No) if yes details	

***Educational Qualification for Act Apprentices (Ex. ITI candidates)***

Academic *8 <sup>th</sup> / 10 <sup>th</sup> Std	Total Mark out of	% of marks	Duration of Course	Name of the institution
	/			
Applying Trade (studied in ITI)	Total Mark out of	% of marks	Duration of Course	Name of the institution
	/			

*(\*8<sup>th</sup> std may be considered against Welder/Painter/carpenter/Wireman Trades only the sufficient candidates had not applied at 10<sup>th</sup> std)*

***Educational Qualification for Trade Apprentices (Fresher to the Trade of Radiology /Pathology)***

Mark secured in 12 <sup>th</sup> Std (Physics, Chemistry and Biology Subject) out of	% of marks	Name of the institution	Applying Trade Radiology / Pathology
/			

10	Whether enrolled as Apprentice earlier(Yes/No)	
11	Postal Order No & date for the amount of `100 (Exemption to SC/ST/PH/Women candidates)	Reason for exemption:
12	Personal Identification marks (as given in Transfer certificate)	1) 2)
13	Whether the wards of serving employee (yes or no) if yes fulfill the format annexed	
14	Ex-Servicemen (Yes or No)	
15	List of documents enclosed with Gazetted officer attestation	

**Declaration of the candidate**

I do hereby declare that all the statements made in the application are true, complete and correct to the best of my knowledge and belief. I understand that in the event of any information being found false or incorrect or in case any ineligibility is detected before, during or after document verification my candidate will stand cancelled and all claims for engagement forfeited.

Signature of candidate (not in capital/Spaced out letter)	Left hand thumb impression	Date:
		Place:

**Check list (Office Use only)**

Details	Yes	No
Application is in the prescribed format		
Photo attestation by Gazetted officer		
Candidate signature in the application form		
Proof enclosed for Date of Birth ,Community, Academic Qualification and Technical qualification (Attested by Gazetted officer)		
Crossed Postal order enclosed ( General/OBC)		

**Grounds of rejection pertaining to applicants**

1	Applications, which are not submitted in format given	
2	Coloured Photograph as prescribed not pasted on the application/without photo Attested by Gazetted officer	
3	Not signed /incompletely signed/illegible signed application/incomplete or illegible application/application signed with capital/spaced out letters	
4	Under - age or Over – age, Date of birth not filled or wrongly filled	
5	Crossed postal order not enclosed,less fees enclosed, invalid IPO, IPO purchased before date of issue of notification and after closing/ other than IPO/less	
6	Copy of OBC/SC/ST community certificate not enclosed belonging to the respective categories	
7	Left & right thumb impression not submitted/blurred/smudged/only left or right thumb impression submitted and Identification marks column not filled up	
8	Non-enclosure of certificate/without Gazetted officer attestation on certificates/No proof enclosed (8 <sup>th</sup> /10 <sup>th</sup> 12 <sup>th</sup> Mark sheet/ ITI mark sheet /Provisional certificate issued by NCVT/SCVT)	
9	Not applied against trade mentioned on notification / irrelevant trade	
10	Not possessing the prescribed % of mark (10 <sup>th</sup> /12 <sup>th</sup> ITI) 50% UR/OBC	
11	Polytechnic, Diploma and Degree Graduate holders	
12	More than one application in single envelop/ double or multiple applications	
13	Any wrong information entered in application form/ Non-compliance of any other instruction/requirement/ Addressed to other unit	
14	Application received before the date of publication of notification and application received after the closing date of notification	
15		

Eligible  
(Tick Mark)

Ineligible  
(Tick Mark)

Committee Member-1

Committee Member-2

Committee Member-3

## Conduct certificate

This is to certify that Shri-----

S/o ----- is known to me for the last ----- years

his/her conduct and character are -----

Signature:

Name

Designation with rubber stamp

### *Certification (for wards of serving Railway employees)*

This is to certify that Mr./Mrs \_\_\_\_\_ Father/Mother/Husband of

Shri/Smt \_\_\_\_\_ is working as \_\_\_\_\_ in

\_\_\_\_\_

Date:

Office Seal:

Designation:

Signature of the supervisory official

Name :

(Note: The wards of serving Railway employees should get the above certification from their immediate supervisor)

**Form-II**

**Disability Certificate**

*(In cases of amputation or complete permanent paralysis of limbs and in cases of blindness)*

*(See rule 4)*

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Recent PP size  
Attested  
photograph  
(showing face  
only) on the person  
with disability

Certificate No. \_\_\_\_\_ Date: / / \_\_\_\_\_  
 This is to certify that I have carefully examined  
 Shri/Smt./Kum \_\_\_\_\_  
 Son/wife/daughter of Shri \_\_\_\_\_ Date of  
 Birth \_\_\_\_\_ Age \_\_\_\_\_ years, male/female \_\_\_\_\_  
 (DD / MM / YY) Registration No. \_\_\_\_\_ permanent resident of House  
 No. \_\_\_\_\_  
 Ward/Village/ \_\_\_\_\_ Street \_\_\_\_\_ Post  
 Office \_\_\_\_\_ District \_\_\_\_\_ State \_\_\_\_\_ whose  
 photograph is affixed above, and am satisfied that :

(A) He/she is a case of:

Locomotor disability  Blindness (Please tick as applicable)

(B) The diagnosis in his/her case is .....

(A) He/she has ..... % (in figure).....percent (in words) permanent physical impairment/blindness in relation to his/her..... (part of body) as per guidelines (to be specified).

2.The applicant has submitted the following documents as proof of residence:-

Nature of Document	Date of issue	Details of authority issuing certificate

\_\_\_\_\_  
 (Signature and Seal of Authorized Signatory of  
 Notified Medical Authority)

\*

\*Signature/Thumb impression of the person in whose favour disability certificate is issued

**Form-III**  
Disability Certificate

(In cases of multiple disabilities)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See rule 4)

Recent PP size Attested photograph (showing face only) on the person with disability
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Certificate No. \_\_\_\_\_ Date: / / \_\_\_\_\_

This is to certify that we have carefully examined  
Shri/Smt./Kum \_\_\_\_\_ son/wife/daughter of Shri  
\_\_\_\_\_ Date of Birth \_\_\_\_\_

(DD / MM / YY) Age \_\_\_\_\_ years, male/female \_\_\_\_\_

Registration No. \_\_\_\_\_ permanent resident of House  
No. \_\_\_\_\_ Ward/Village/ \_\_\_\_\_

Street \_\_\_\_\_ Post Office \_\_\_\_\_

District \_\_\_\_\_ State \_\_\_\_\_ whose photograph is affixed  
above, and are satisfied that :

(A) He/she is a Case of Multiple Disability. His/her extent of permanent physical Impairment/disability has been evaluated as per guidelines (to be Specified) for the disabilities ticked below, and shown against the relevant disability in the table below:

Sl. No	Disability	Affected part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1	Locomotor disability	@		
2	Low vision	#		
3	Blindness	Both Eyes		
4	Hearing impairment	\$		
5	Mental retardation	X		
6	Mental-illness	X		

(B) In the light of the above, his/her over all permanent physical impairment as per guidelines (to be specified), is as follows:-

In figures:- \_\_\_\_\_ percent.

In words:- \_\_\_\_\_ percent.

2. This condition is progressive/non-progressive/likely to improve/ not likely to improve.

3. Reassessment of disability is:

(i) not necessary, or (ii) is recommended / after \_\_\_\_\_ years \_\_\_\_\_ months, and therefore this certificate shall be valid till \_\_\_\_\_ (DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

# e.g. Single eye/both eyes.

\$ e.g.: Left/Right/both ears.

4. The applicant has submitted following document as proof of residence:-

Nature of Document	Date of issue	Details of authority issuing certificate

5. Signature and seal of the Medical Authority.

Name and seal of Member	Name and seal of Member	Name and seal of Member

Chairperson

*
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\*Signature/Thumb impression of the person in whose favour disability certificate is issued

**Form-IV****Disability Certificate**

(In cases other than those mentioned in Forms-II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See rule 4)

Recent PP size Attested photograph (showing face only) on the person with disability
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Certificate No. \_\_\_\_\_

Date: / /

This is to certify that I have carefully examined Shri/Smt./Kum  
\_\_\_\_\_ son/wife/daughter of Shri  
\_\_\_\_\_ Date of Birth \_\_\_\_\_

(DD / MM / YY) Age \_\_\_\_\_ years, male/female \_\_\_\_\_

Registration No. \_\_\_\_\_ permanent resident of House No. \_\_\_\_\_

Ward/Village/ \_\_\_\_\_ Street \_\_\_\_\_ Post \_\_\_\_\_

Office \_\_\_\_\_ District \_\_\_\_\_

State \_\_\_\_\_ whose photograph is affixed above, and am satisfied that  
he/she is a case of \_\_\_\_\_ disability. His/her extent of percentage physical  
impairment/disability has been evaluated as per guidelines (to be specified and is shown against the  
relevant disability in the table below:-

S.No	Disability	Affected part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1	Locomotor disability	@		
2	Low vision	#		
3	Blindness	Both Eyes		
4	Hearing impairment	\$		
5	Mental retardation	X		
6	Mental-illness	X		

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive/non-progressive/likely to improve/ not likely to improve.

3. Reassessment of disability is: (i) not necessary, OR (ii) is recommended/ after  
\_\_\_\_\_ years \_\_\_\_\_ months, and therefore this certificate shall be valid till \_\_\_\_\_  
\_\_\_\_\_ (DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

# e.g. Single eye/both eyes.

\$ e.g.: Left/Right/both ears.



4. The applicant has submitted following document as proof of residence

Nature of Document	Date of issue	Details of authority issuing certificate.

(Authorized Signatory of notified Medical Authority)  
(Name and Seal)

{Countersignature and seal  
of the CMO/Medial Superintendent/  
Head of Government Hospital, in  
case the certificate is issued by a  
medical authority who is not a  
servant government (with seal)}

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\*Signature/Thumb impression of the person in whose favour disability certificate is issued

**Note:** In case this certificate is issued by a medical authority who is not a government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District.

**Note:** The principal rules were published in the Gazette of India vide notification number S.O.908 (E) dated the 31st December, 1996.

## Annexure-VI

### NAME & ADDRESS OF THE INSTITUTE /HOSPITAL DISABILITY CERTIFICATE

Certificate No.....

1.This is certified that Smt./Shri Kum\*..... son/daughter of Shri..... age.....sex Male/Female having identification marks as below is suffering from permanent disability of following category:

- A. Locomotor or cerebral palsy:  
 (i)BL-Both legs affected but not arms.  
 (ii)BA-Both arms affected:  
 (a)Impaired reach (b) Weakness of grip  
 (iii)OL-One leg affected (right or left)  
 (a)Impaired reach (b) Weakness of grip (c)Ataxic  
 (iv)OA-One arm affected (right or left)  
 (a)Impaired reach (b)Weakness of grip (c)Ataxic  
 (v)BH-Stiff back and hips(cannot sit of stoop)  
 (vi)MW-Muscular weakness and limited physical endurance.  
 B. Blindness or Low Vision: (i) B-Blind (ii)PB-Partially Blind  
 C. Hearing Impairment: (i) D-Deaf (ii)PD-Partially Deaf  
 (Delete the category whichever is not applicable)

Paste here your recent coloru photo showing the disability(The photograph should be attested by the chairperson of the Medical Boar

\* Signature of candidate

2. This is certified that Smt./Shri/Kumari ..... being unable to perform the Typing Skill Test because of his/her physical disability i.e. .... (indicate the category whichever is applicable) may be exempted from Typing Skill Test.

3. This condition is progressive/non-progressive/likely to improve/not likely to improve. Reassessment of this case is not recommended/is recommended after a period of.....years.....months.

4. Percentage of disability in his/her case is .....%

5. Smt./Shri/kum.....meets the following physical requirement for:

- |   |        |
|---|--------|
| i. F-Can perform work by manipulating with fing   | Yes No |
| ii. PP-Can perform work by pulling and pushing    | Yes No |
| iii. L-Can perform work by lifting                | Yes No |
| iv. KC-Can perform work by kneeling and crouching | Yes No |
| v. B-Can perform work by bending                  | Yes No |
| vi. S-Can perform work by sitting                 | YesNo  |
| vii. ST-Can perform work by standing              | YesNo  |
| viii. W-Can perform work by walking               | Yes No |
| ix. SE-Can perform work by Seeing                 | Yes No |
| x. H-Can perform work by hearing/speaking         | Yes No |
| xi. RW-Can perform work by reading and writing    | Yes No |

Signature of Doctor) Name: Registration No. Member, Medical Board	Signature of Doctor) Name: Registration No. Member, Medical Board	Signature of Doctor) Name: Registration No. Member, Medical Board

\*Please delete the words which are not applicable

Place:

Date: \_\_\_\_\_ Counter signature of the Medical Superintendent/ CMD/ \_\_\_\_\_ Head of Hospital (with seal)

**Note:** (1) According to the Persons with Disabilities (Equal Opportunities, Protection of Right and Full Participation) Rules, 1966 notified on 31.12.1996 by the Central Government in exercise of the powers conferred by sub-Section (1) and (2) of section 73 of the Persons with disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996), authorities to give disability Certificate will be a Medical Board duly constituted by the Central or the State Government. The State Government may constitute a Medical Board consisting of at least three members out of whom at least one shall be a specialist in the particular field for assessing the locomotor/hearing and speech/Visual disability. (ii) The certificate would be valid for a period of 5 years of those whose disability is temporary. For those who acquired permanent disability, the validity can be shown as 'permanent.