



DECLARATION OF INTEREST FORM



NAME: _____
ADDRESS: _____

POSITION: _____
DEPARTMENT: _____

DATE: _____
SIGNATURE: _____
OFFICE: _____

DATE: _____
SIGNATURE: _____
OFFICE: _____

DATE: _____
SIGNATURE: _____

DATE: _____
SIGNATURE: _____
OFFICE: _____

DATE: _____
SIGNATURE: _____
OFFICE: _____

DECLARATION OF INTEREST FORM

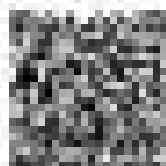
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- 1. I am not a member of any political party, organization, or association.
- 2. I am not a member of any religious organization.
- 3. I am not a member of any labor union.
- 4. I am not a member of any other organization.

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MINISTRY OF HEALTH AND FAMILY WELFARE GOVERNMENT OF INDIA

SRI
OFFICE OF THE SECRETARY

Ministry of Health and Family Welfare
Government of India

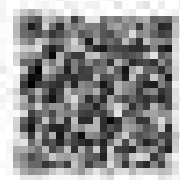
Ministry of Health and Family Welfare
Government of India

Ministry of Health and Family Welfare, Government of India, New Delhi-110002

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