

Central Railway

Office of the  
Chief Medical Superintendent  
Divisional Railway Hospital , Solapur -413001  
Date : 26-10-2023

U/MD/HVS/2023/8

**Notification No: U/MD/HVS/2023/8 dated 26-10-2023****Engagement of Honorary Visiting Specialists on Solapur Division of Central Railway**

Applications are invited for HONORARY VISITING SPECIALISTS from the Doctors fulfilling the following qualifications and experience for various hospitals of Solapur division. The details of vacancies in various Railway hospitals on Solapur Division of Central Railway and other details are given below.

|  |  |                              |           |  |
|--|--|------------------------------|-----------|--|
| Qualification                            | <ul style="list-style-type: none"><li>Post Graduate degree from a recognized University. Minimum 3 years experience in the professional work related to concerned Speciality after obtaining P.G degree.</li><li>Where suitable candidates with PG degree are not available PG Diploma holders with 5 years experience in the professional work in concerned Specialty after obtaining P.G Diploma</li></ul>   |                              |           |  |
| Age                                      | <ul style="list-style-type: none"><li>During First time engagement, the preferred age is between 30 years to 64 years.</li><li>Upper age limit of continued engagement is 65 years.</li></ul>  |                              |           |  |
| Tenure                                   | <ul style="list-style-type: none"><li>Each time the offer is given one year only. After expiry of one year, extension can be given for one year each on satisfactory performance of previous year</li></ul>  |                              |           |  |
| Vacancy                                  | 09 (Nine )   |                              |           |  |
|  | SN   | Speciality                   | No of HVS | Location                                   |
|  | 1  | Orthopedician                | 01        | Divisional Railway Hospital, Solapur       |
|  | 2  | Radiologist                  | 01        |  |
|  | 3  | Surgeon                      | 01        |  |
|  | 4  | Ophthalmologist              | 01        |  |
|  | 5  | Physician                    | 01        | Sub Divisional Railway Hospital, Kurduwadi |
|  | 6  | Surgeon                      | 01        |  |
|  | 7  | Obstetrician & Gynaecologist | 01        |  |
|  | 8  | Physician                    | 01        | Sub Divisional Railway Hospital, Daund     |
| 9  | Obstetrician & Gynaecologist   | 01                           |           |  |
| Duty Hours                               | <ul style="list-style-type: none"><li>2 hrs a day for 6 days/week regularly (During OPD hours 09.00 to 13.00 hrs &amp; 15.30 to 17.30 hrs).</li><li>In addition they will have to come to Hospital whenever called in for emergency on any day, including Sunday and at any time of the day.</li></ul>   |                              |           |  |
| Honorarium                               | Rs. 52000/- Per month  |                              |           |  |
| Rate of deduction of remuneration        | They are allowed to have 12 days leave every year. For any absence beyond 12 days, deductions will be made Rs.2167/-per day  |                              |           |  |
| Free Railway Passes                      | <ul style="list-style-type: none"><li>One set of complimentary Railway Pass valid all over Indian Railway &amp; Konkan Railway in AC two tier including Rajdhani Express and in AC Chair Car of Shatabdi Express for self + spouse and dependent Children (as per rules applicable for Railway employees) will be made available as per the entitlement.</li><li>The complementary pass can be availed after 3 months of engagement for the calendar year.</li></ul> |                              |           |  |
| Termination of contract                  | The contract may be terminated at any time, on one month notice on either side. The Administration reserves the right not to assign any reason for such Termination.   |                              |           |  |
| Application Fee                          | Nil  |                              |           |  |
| Last Date for Submissions of application | The application forms duly filled in with supporting documents should be dropped into the box kept in the office of Chief Medical Superintendent, Divisional Railway hospital Solapur on or before 11:00 hours of 30-11-2023.  |                              |           |  |

Other terms and conditions related with this engagement and the application form can be obtained from the office of Chief medical superintendent, Divisional Railway Hospital, Solapur on any working days from 11.00 hours to 13.00 hours or can be downloaded from below mentioned website. <http://cr.indianrailways.gov.in>. → About Us → Divisions → Solapur → Medical → Sr. No 11

Chief Medical Superintendent  
Divisional Railway Hospital ,Solapur

# APPLICATION & SELF DECLARATION FORM FOR EXPRESSION OF INTEREST FOR THE POST OF HONORARY VISITING SPECIALIST

Paste Passport size  
self-attested Photograph  
here

To,  
Chief Medical Superintendent,  
Divisional Railway Hospital, Solapur -413001

**Name of the HVS Post (Speciality ) :** \_\_\_\_\_

**A. PERSONAL DETAILS (ANY SUPPRESSION OF FACTS OR FALSE INFORMATION WILL LEAD TO CANCELLATION OF CANDIDATURES).**

|    |                           |              |
|----|---------------------------|--------------|
| 1. | NAME (IN BLOCK LETTERS)   |              |
| 2. | DATE OF BIRTH             |              |
| 3. | AGE on 01.11.2023         | Years Months |
| 4. | FATHER'S NAME             |              |
| 5. | MARITAL STATUS            |              |
| 6. | PRESENT MAILING ADDRESS   |              |
| 7. | PERMANENT MAILING ADDRESS |              |

**B. MEANS FOR COMMUNICATION**

|    |                              |  |
|----|------------------------------|--|
| 1. | E.MAIL ID                    |  |
| 2. | Mobile No                    |  |
| 3. | Land Line No (With STD Code) |  |

**C. IDENTIFICATION DETAILS  
ESSENTIAL**

|    |             |  |
|----|-------------|--|
| 1. | PAN CARD NO |  |
|----|-------------|--|

**OPTIONAL (ANY TWO)**

|    |                     |  |
|----|---------------------|--|
| 2. | VOTER ID NO         |  |
| 3. | AADHAAR CARD NO     |  |
| 4. | PASSPORT NO         |  |
| 5. | DRIVING LICENSE, NO |  |

**D. EDUCATIONAL QUALIFICATION****MBBS**

|    |                   |  |
|----|-------------------|--|
| 1. | UNIVRSITY/COLLEGE |  |
| 2. | YEAR OF PASSING   |  |
| 3. | MARKS OBTAINED    |  |

**MD/MS/DIPLOMA/DNB**

|    |                   |  |
|----|-------------------|--|
| 1. | UNIVRSITY/COLLEGE |  |
| 2. | YEAR OF PASSING   |  |
| 3. | SUBJECT           |  |
| 4. | MARKS OBTAINED    |  |

**ANY OTHER ADDITIONAL QUALIFICATION**

|    |                   |  |
|----|-------------------|--|
| 1. | UNIVRSITY/COLLEGE |  |
| 2. | YEAR OF PASSING   |  |
| 3. | SUBJECT           |  |
| 4. | MARKS OBTAINED    |  |

**E. PUBLICATIONS WITH DETAILS, IF ANY**

| SN | JOURNAL /BOOK | TITLE OF PUBLICATION | YEAR OF PUBLICATION |
|----|---------------|----------------------|---------------------|
| 1. |               |                      |                     |
| 2. |               |                      |                     |
| 3. |               |                      |                     |

**F. DETAILS OF EXPERIENCE**

| SN | NAME & ADDRESS OF INSTIUTION | TOTAL PERIOD WITH DATES | NATURE OF JOB RESPONSIBILITIES HELD |
|----|------------------------------|-------------------------|-------------------------------------|
| 1. |                              |                         |                                     |
| 2. |                              |                         |                                     |
| 3. |                              |                         |                                     |
| 4. |                              |                         |                                     |
| 5. |                              |                         |                                     |

## G. REGISTRATION DETAILS

|                          |                                      |
|--------------------------|--------------------------------------|
| MEDICAL COUNCIL OF INDIA | STATE MEDICAL COUNCIL NAME OF STATE: |
|                          |                                      |
| REGISTRATION NO :        | REGISTRATION NO :                    |
| DATE :                   | DATE :                               |
| VALIDITY PERIOD :        | VALIDITY PERIOD :                    |

H. **DETAILS OF ENCLOSURES: SELF ATTESTED PHOTOCOPIES OF FOLLOWING DOCUMENTS TO BE SUBMITTED WITH APPLICATION FORM**

| SN  | Type of document submitted                                   | Whether Submitted (Yes/No) | If NO, Give Reasons there for | Remarks ( By the Scrutinizing Official |
|-----|--|----------------------------|-------------------------------|--|
| 1.  | Date of Birth certificate                                    |                            |                               |  |
| 2.  | Marksheets of MBBS examination                               |                            |                               |  |
| 3.  | Degree certificate of MBBS                                   |                            |                               |  |
| 4.  | Internship Completion Certificate                            |                            |                               |  |
| 5.  | MCI/STATE Registration Certificate                           |                            |                               |  |
| 6.  | State medical council registration certificate               |                            |                               |  |
| 7.  | Speciality Degree /Diploma certificate                       |                            |                               |  |
| 8.  | Work experience certificate                                  |                            |                               |  |
| 9.  | Details of publication /presentation /lectures in conference |                            |                               |  |
| 10. | Pan card   |                            |                               |  |
| 11. | Voter id card  |                            |                               |  |
| 12. | Adhar card   |                            |                               |  |
| 13. | Passport   |                            |                               |  |
| 14. | Driving licence  |                            |                               |  |

**DECLARATION**

I, Dr. \_\_\_\_\_  
s/d/o\_\_\_\_\_ hereby solemnly declare  
that statements made above by me are correct and true to the best of my knowledge and  
belief.

Further, I, do undertake that the above statements, if found false at any stage in  
future, my appointment shall be cancelled by the administration and I shall be liable for  
punitive and disciplinary action whatever applicable.

The decision of Selection committee appointment by competent authority shall  
be final.

( \_\_\_\_\_ )  
SIGNATURE OF CANDIDATE

- Self Bank Account details to be provided instead of Hospital Bank Account details

**RTGS/NEFT FORM**

I hereby agree to get my payment through NEFT/RTGS.

| Sr. No | Particulars                 |                       |
|--------|-----------------------------|-----------------------|
| 01.    | Name of A/C holder.         |                       |
| 02.    | Name of Bank                |                       |
| 03.    | Branch Name.                |                       |
| 04.    | Account Number.             |                       |
| 05.    | Account Type                |                       |
| 06.    | IFSC Code.                  | <b>Current/Saving</b> |
| 07.    | MICR Code.                  |                       |
| 08.    | Address of Bank             |                       |
| 09.    | Telephone No. of Bank       |                       |
|        | Mobile No. of Bank          |                       |
|        | E-mail No. of Bank          |                       |
| 10.    | Address of A/C holder       |                       |
|        | Telephone No. of A/C holder |                       |
|        | PAN No. of A/C holder       |                       |
|        | E-mail No. of A/C holder    |                       |

I hereby certify that above information is correct & true to my knowledge.

Signature and Seal of Bank

Signature and Seal of Firm