

18, संस्थागत क्षेत्र, शहीद जीत सिंह मार्ग, नई दिल्ली - 110016

KENDRIYA VIDYALAYA SANGATHAN (HO)

18, Institutional Area, S.J.S. Marg, New Delhi-110016 दरभाष/Tel.:011-26521898 फैक्स/Fax: 26514179

E-mail - kvs.estt.1@gmail.com

F.11048/1-2/2020-KVS HO (Estt-I) / 1653-1682

Date: 31.05.2021

The Deputy Commissioner/Director All Regional Offices/ZIETs & Principal All Kendriya Vidyalayas

Sub: Annual Request Transfer in respect of Principals Grade-II/ Vice Principals of Kendriya Vidyalayas and Section Officers/Finance Officers/Administrative Officers/Assistant Commissioners/Deputy Commissioners/Directors of Education Officers/Assistant Regional Offices/ZIETs/KVS(HQ) for the year 2021-22- Invitation of Applications- Reg.

Madam/Sir,

In continuation of this office letter of even no. dated 28.05.2021, it has also been decided to invite applications from Principals Grade-II/Vice Principals of Kendriya Vidyalayas and Section Officers / Finance Officers / Administrative Officers / Assistant Education Officers / Assistant Commissioners / Deputy Commissioners / Directors of Regional Offices / ZIETs / KVS (HQ) for considering request/administrative transfers during the year 2021-22. The Competent Authority has also decided to call for the five choice stations to consider transfers of these officers in the event of transfer in public interest/on their own request. To facilitate this, all ranks of employees, as stated above, need to fill up Part-A of the application. Part-B needs to be filled up only by those employees who are seeking transfer on request.

02. INFORMATION TO ALL CONCERNED

Awareness of the instructions in proper perspectives is required to fill up the application form as desired. Therefore, sufficient copies of this letter along with the application form be prepared. One copy is meant for official use and others are to be provided to concerned employees underreceipt.

03. **HOW TO APPLY**

All employees, as mentioned above, are permitted to prefer only one application (in triplicate/duplicate, as the case may be) in the prescribed format after going through the instructions contained in this letter. Overwriting is not allowed. Each column/part of the application form should be filled properly. No page of the application is to be removed. Column/parts/pages, not applicable/not filled/not to be used, should be crossed and each page of the application be signed by the concerned employee.

04. SAFEGUARD AGAINST EXTRANEOUS INFLUENCE

Employees shall not bring in any outside influence in service matters. If such an influence from any source, espousing the cause of an employee, is received it shall be presumed that the same has been brought in by the concerned employee. The request of/for such an employee shall not be considered. Action may also be initiated against such an employee under relevant service rules. Attention of all concerned is also drawn to the provision of Article 59 (27) of Education Code, Rule 20 of CCS (Conduct) Rules.

05. FORMAT AND ENCLOSURES

The application, when produced, must conform to the given format both in form and content. Medical certificate in support of medical ground and declaration regarding employment of spouse are part of the application. These should be obtained on the body of the form itself to avoid detachment. Application and enclosures should be tagged properly by numbering each page. No enclosure will be kept separately. Irrelevant enclosures are not to be attached.

06. <u>SIGNING/ENDORSEMENT/VERIFICATION/COUNTERSIGNING</u>

- I. The application and declaration wherever necessary must be signed by the employee himself/herself. Application submitted by spouse, parents or others, for and/or on behalf of the employee is not acceptable and should not be forwarded. Medical Certificate must bear the signature of the <u>Civil Surgeon/or equivalent</u>.
- Application of a subordinate must be endorsed by the Chairman VMC KV concerned/ II. Principal, KV concerned/Deputy Commissioner/Director of the Regional Office/ZIET concerned (as the case may be) after satisfying himself/herself regarding correctness of the entries made by the applicant. It has been observed in the past that the details furnished by the applicants are not subjected to proper verification before endorsing the application. Any wrong information filled by the applicant and duly endorsed/countersigned by the Principal, KV concerned/ Deputy Commissioner/Director of Regional Office/ZIET concerned will attract disciplinary action against the applicant as well as the endorsing/counter- signing authority. This is to be taken with utmost seriousness. Principal of the Kendriya Vidyalaya concerned Commissioner/Director of the Regional Office/ZIET concerned are requested to ensure correctness of the entries, so that wrong information does not find place in the application form.

07. SUBMISSION OF APPLICATION

Three copies each of the applications should be endorsed by the Chairman VMC KV concerned/ Principal, KV concerned/Deputy Commissioner/Director of the Regional Office/ZIET concerned (as the case may be). Out of these three copies, one copy may be retained in the Vidyalaya office and two copies may be sent to Deputy Commissioner so as to reach the Regional Office concerned latest by 11.06.2021. The Deputy Commissioner/Director ZIET after filling required information and after due verification/endorsement/recommendation on both copies may retain one copy in Regional Office/ ZIET Office and send one copy to Assistant Commissioner (Estt.1), KVS (HQ) so as to reach KVS (HQ) latest by 21.06.2021.

All applications in original duly completed in all respects will be forwarded to KVS (HQ) by Post & scanned copy by the stipulated date

A check-list, certifying that applications in respect of all rank of employees as stated above under his/her jurisdiction are being forwarded, to be enclosed by the concerned Deputy Commissioner.

Beside the above, the data compiled in excel formats (Annexure-I to VI) be sent to KVS(HQ) at e-mail kvs.estt.1@gmail.com latest by 21.06.2021. Annexure-III regarding recommendations for administrative transfers may be sent separately and confidentially to e-mail ID of Sh. Anurag Bhatnagar, AC (Estt-I) anuragbhatnagar273@gmail.com by the Deputy Commissioner concerned using his/her own e-mail ID.

08. <u>LATE OR INCOMPLETE APPLICATION</u>

Applications received late or incomplete applications may not be entertained. Hence, the target date given in preceding Para 7 be strictly adhered to.

This issues with the approval of the Competent Authority.

Yours faithfully,

(Dr. E.Prabhakar) Joint Commissioner (Admn.)

Encl: Formats of application form for all categories. -Total 8 pages each.

Copy to:

1. PS to the Commissioner, KVS for information.

2. PS to the Additional Commissioner (Acad/Admn), KVS for information.

3. Incharge EDP Cell, KVS(HQ), New Delhi – for uploading on KVS(HQ) website under the head "Announcement".

4. Guard file.

KENDRIYA VIDYALAYA SANGATHAN

ANNUAL TRANSFER APPLICATION FOR PRINCIPAL G-II/ VICE- PRINCIPAL/AEOs FINANCE OFFICER/SECTION OFFICERS OF KV/KVS RO/ZIET -2021-22 PART-A (MANDATORY FOR ALL EMPLOYEES)

1.	Name	: (Sh./Sr	nt./Ms./N	Miss) -	- Tick whic	hever	appli	cable	; 		1	T		
2.	Emple	ovee Coo	de as per	IIBI r	ortal :					, , , , ,				
3.	i)	Post he	eld	C	:									
	ii)		f appoint present po											_
4.	Preser	nt place	of postin	g	:				_					
5.	Date of	of Birth			:									
6.			vith Distr er servic		rds):									_
7.		-	g in the p (dd/mm/		;									
8.	Date of	of joining	g at the p m/yyyy)	resent	:	-					_	•		_
9.		•	0000		•									
	If yes,	name of	f the Dep	partme	nt	**		ne.				_	,	
	-		_		:									
			spouse is											
10.					Tick which	never	appl	icabl	e and	Cros	s wh	iche	ver	not
	applic	able):		ON AD										
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	LTR	able):	DFP		MN. GROUND	ON F	EQUES	T	IN PUBI	LIC INTE				
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Note: To be filled in Chronological order. Details of present posting not to be filled in this table.

giver	do hereby affirm that the information in the column No. 1 to 12 of the part A of the application is correct. I understand that ag/suppressed information shall render me liable for disciplinary action.
Plac Date	e:e:
	(Signature of the applicant)
in e	Name
	Designation
	KV/KVS RO/ZIET
1.	(To be filled by Regional Office) Certified that *No disciplinary case is pending or contemplated/Disciplinary case is pending/contemplated against Sh./Smt./Mss./Miss (If a disciplinary case is pending /contemplated, a brief of the case may be mentioned):
2.	Certified that the details furnished by the applicant have been verified from his/her service records and are found correct.
3.	He/Shewas *on leave/absent/absent without pay during (period). He/Sheis *still away/presently not away from duties.
*Stri	(Signature) Deputy Commissioner KVSRO ke off whichever is not applicable

(Office Seal)

PART-B (TO BE FILLED ONLY FOR REQUEST TRANSFER)

1.	Name: (Sh./Smt./Ms./Miss) – Tick whichever applicable
2.	Employee Code as per UBI portal :
3.	i) D/1.11
	ii) Post held : ii) Date of appointment : in the present post
4.	Present place of posting :
5.	Date of Birth (dd/mm/yyyy):
6.	Date of joining in the present KV/RO/ZIET (dd/mm/yyyy):
7.	Date of joining at the present :Station (dd/mm/yyyy)
8.	Is spouse working (Yes/No) : If yes, name of the Department In which spouse is working :
	Station where spouse is working:
9.	Have you given the Declaration regarding the employment of spouse: (Yes/No)
10.	Ground for seeking transfer: (LTR/ MDG /DFP/Spouse case/Other-Specify)
11.	<u>Five choice stations in order of preference</u> : Five choice stations in order of preference. One choice is mandatory if applying for request transfer. Choice/choices should be different from present station. No KV choice should be filled.
	Sl. Name of Choice Station/s
	1.
	2.
	3. 4.
	5.
12. I	Completion of 3 years' continuous stay in NER/Hard station as on 30 06 2021 excluding
I	the period of absence (Yes/No) I. Completion of 5 years' continuous stay at present station (other than NER/Hard station) as on 31.03.2021 excluding the period of absence (Yes/No)

	®
I, Shri/Smt/Ms./Miss	do her
	ation given in the column No. 1 to 13 of the Part-B of
	ad *medical certificate and declaration furnished is/are bona
(*strike out if not appl render me liable for disc	licable). I understand that wrong/suppressed information sciplinary action.
Place:	
Date:	(Signature of the applic
	Name
	Designation
	KV/KVS RO/ZIET
n1/n	ions of Chairman VMC (only in case of Principal Gr
Principal (in case of Vic	
Principal (in case of Vic	ee-Principal).
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Principal (in case of Vic	ce-Principal).
Principal (in case of Vice Place: Date: Remarks/Recommendate	Sig. of Chairman, VMC/ Princtions for transfer (by Deputy Commissioner, RO/Directions)
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Principal (in case of Vice Place: Date: Remarks/Recommendate ZIET) -	Sig. of Chairman, VMC/ Princions for transfer (by Deputy Commissioner, RO/Directions)
Principal (in case of Vice Place: Date: Remarks/Recommendate ZIET) -	Sig. of Chairman, VMC/ Princions for transfer (by Deputy Commissioner, RO/Directions)
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Principal (in case of Vice Place: Date: Remarks/Recommendate ZIET) -	Sig. of Chairman, VMC/ Prince
Principal (in case of Vice Place: Date: Remarks/Recommendate ZIET) -	Sig. of Chairman, VMC/ Prince ions for transfer (by Deputy Commissioner, RO/Directions)
Principal (in case of Vice Place: Date: Remarks/Recommendate ZIET) -	Sig. of Chairman, VMC/ Princtions for transfer (by Deputy Commissioner, RO/Directions) for transfer (by Deputy Commissioner) for trans
Principal (in case of Vice Place: Date: Remarks/Recommendate ZIET) - It is certified that the in	Sig. of Chairman, VMC/ Prince ions for transfer (by Deputy Commissioner, RO/Director) Information given in the application form has been verified for correct.
Principal (in case of Vice Place: Date: Remarks/Recommendate ZIET) - It is certified that the in	Sig. of Chairman, VMC/ Prince ions for transfer (by Deputy Commissioner, RO/Directions)

MEDICAL CERTIFICATE

(TO AVOID DISQUALIFICATION, PLEASE DO NOT USE ABBREVIATION, FILL IN CAPITAL LETTERS ONLY. PLEASE DO NOT ATTACH ANY ENCLOSURE EXCEPT WHERE SPECIFICALLY ASKED FOR) Name of Patient: Relation of the patient with the employee: (Self/spouse/son/daughter) Address of the Doctor Contact No. _____(Land Line) (Mobile) Date: Certificate I, Dr. _____ with Medical Council Registration hereby certify that Shri/Smt./Ms./Miss/Master____ No. aged _______*who himself/herself is a KVS employee or *son/daughter/wife/husband of Sh./Smt./Ms. (Name of KVS employee) is suffering from the disease/diseases with the details as follows and that treatment of this disease is not at all available at this station or in its vicinity (*Strike off whichever is not applicable). IN CASE OF CARCINOMA A) 1. Name of carcinoma with site affected: 2. Date when it was detected first: 3. Brief history-Pathological report with reference No. & dates: T.N.M classification (if applicable): 4. Evidences in support of uncontrolled growth 5. Evidences in support Metastasis: 6. Condition of neighboring or surrounding structures: 7. Treatment being continued (in brief): 8. Full name of surgery/surgeries in connection with dates: 9. (Signature of the Doctor) (Signature of the applicant)

B) IN CASE OF RENAL FAILURE

- Name of disease causing Renal failure: 1.
- Evidences in support of Chronic Irreversible changes: 2.
- Number of Dialysis done with dates: 3.
- Kidneys involved (single/both): 4.
- Any surgery including renal transplantation done (Yes/No): 5.

IN CASE OF LOSS OF MUSCLE POWER C)

- How many extremities are affected?: 1.
- 2. Grading of muscle power at present:
- Grading of muscle power at the onset of disease: 3.
- Duration of loss of muscle power: 4.
- Any recovery after the onset till date: 5.
- Most Direct cause of loss of Muscle Power: 6.

D) IN CASE OF HEART DISEASE

- Name of the surgical procedure undergone. CABG/Angioplasy: 1.
- Date of surgical procedure: 2.
- Name of Doctor-Surgeon: 3.
- 4. Name of Hospital:

IN CASE OF THALASSEMIA E)

- Name of disease (with specification- major or minor): 1.
- 2. Date of first detection:
- Whether blood transfusion required? (Yes/No): 3.
- If so, periodicity of duration of blood transfusion/replacement 4. required by the patient/chelation therapy:
- 5. Blood transfusion done last:____ (DD/MM/YYYY)

IN CASE OF PARKINSON'S DISEASE F)

- 1. Date of detection of disease:
- Duration of treatment undergone: 2.
- Date & designation of treating Neurologist: 3.
- Whether admitted in hospital & if so, details thereof: 4.
- Progressiveness of the disease-please specify: 5. (To be certified by a neurologist)

IN CASE OF MOTOR - NEURON DISEASE G)

- 1. Date of detection of the disease:
- 2. Duration of treatment undergone:
- Name & designation of the treating neurologist 3. 4.
- Result of EMG test report & MRI:
- Grading of muscle power at present: 5.

(The Doctor is requested to "Cross" the A/B/C/D/E/F/G above whichever is not applicable in the case of the Patient)

(Signature of the Doctor)

(Signature of the applicant)

Place :	
Date :	
	(Signature of the Civil Sur
	Name
	Name of the Deptt.
	Name of the Hospital
	Seal:
Signature and name of the	
KVS employee (applicant) :	
Signature and Name of the Pat	ient:

DECLARATION FOR WORKING SPOUSE (IN KVS/GOVT. SECTOR)

I,		Nome	f. 1	
declare that m	y spouse	(Name	oi employee)	solemnl
at	_ (Name of the station) wh	ich is my *mass	e) is presently	employe
distance of my	present station or my choice s	tation/within 100	station/within	100 km
The spouse is en	mployed in KVS/Govt. sector	as	kms of my choic	ce station
spouse). His/Her	full office address with name	as Dosionation	(designat	tion of the
follows:	value address with hame	e & Designation of	of immediate sup	erior is as
Name and office	address (with Din Codo) and	G		
	address (with Pin Code) of the		_	
Contact-	(I and I ina)		– e)	
	(Land Line)			
Name & office ad Officer of the Spo	ldress (with Pin Code) of imme	ediate Superior		
Name & office ad Officer of the Spo	dress (with Pin Code) of imme ouse: (Land Line)	ediate Superior	-	
Name & office ad Officer of the Spo	dress (with Pin Code) of immouse:(Land Line)	ediate Superior (Mobile	-	
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Name & office ad Officer of the Sport Contact	dress (with Pin Code) of immeduse: (Land Line) oyee:	ediate Superior (Mobile	-	

KENDRIYA VIDYALAYA SANGATHAN

ANNUAL TRANSFER APPLICATION FOR ASSISTANT COMMISSIONERS/ ADMINISTRATIVE OFFICERS OF REGIONAL OFFICES- 2021-22 PART-A (MANDATORY FOR ALL)

1.	Name: (Sh./Smt./Ms./Miss) – Tick which	chever applicable	le			
2.	Employee Code as per UBI portal:					
3.	i) Post held :					
	ii) Date of appointment in the : present post (dd/mm/yyyy)					
4.	Present place of posting :			_		
5.	Date of Birth (dd/mm/yyyy) :					
6.	Home Town with District & State/UT (As per service records) :					
7.	Date of joining in the present RO (dd/mm/yyyy) :					
8.	Date of joining at the present : Station (dd/mm/yyyy)		-			
9.	If yes, Name of the Department					
	Station where spouse is working :		******			
10.	Reason for last transfer (Tick whichever LTR MDG DFP ON ADM GROUIND			PUBLIC	applicable): ANY OTHER	
11.	Five choices in order of preference (In cas	e of mandatory	transfer in p	ublic in	terest):	
	Sl. Choices of Place of Place 1. 2. 3. 4. 5. 5.	Posting (Name	of RO/KVS	HQ)		
12.	Details of last 03 transfers (on any post in	KVS), if any:				
	Sl. Post held Name of KV/RO/ZIET		(Dates) n.yyyy) To	trans	son(s) for sfer out of the tioned RO/ZIET/HQ	
	1.					
	2.					
	1 3. 1		1			

Note: To be filled in Chronological order. Details of present posting not to be filled in this table.

	I, Sh./Smt./Ms./Missdo hereby	affirm that the information given
in the inform	e Sl. No. 1 to 12 of Part A of the application is correct. I u mation shall render me liable for disciplinary action.	nderstand that wrong/suppressed
Date:	e: >:	£
Date.	·	(Signature of 1)
		(Signature of the applicant)
	N	Jame
	D	esignation
	K	VS RO
	(To be filled by Regional Office)	
1.	. Certified that *No disciplinary case is pending or co pending/contemplated against Sh./Smt./Ms./Miss disciplinary case is pending /contemplated, a brief of the case	may be mentioned): (If a
	Certified that the details furnished by the applicant have be records as available in this office and are found correct. He/Shewas *on leave/absent/absent without pay during *still away/presently not away from duties.	
		(Signature) Deputy Commissioner KVSRO
*Strike	e off whichever is not applicable	
		(Office Seal)
	[To be certified by KVS(HO)]	

Certified that the details furnished bythe applicant have been verified from the service records and found correct.

> (Signature) Assistant Commissioenr (Estt.-I) KVS(HQ), New Delhi

PART-B (TO BE FILLED ONLY FOR REQUEST TRANSFER)

mployee Code as per UBI portal :
Post held :
Post held : Date of appointment : in the present post
resent place of posting :
ate of Birth(dd/mm/yyyy):
ate of joining in the present O/ZIET (dd/mm/yyyy):
ate of joining at the present:ation (dd/mm/yyyy)
spouse working (Yes/No) : yes, Name of the Department which spouse is working :
ration where spouse is working:
ave you given the declaration garding the employment of spouse: (Yes/No)
round for seeking transfer: TR/ MDG /DFP/Spouse case/Other-Specify)
choice stations in order of preference (in case of transfer on own request):
Choices of Place of Posting (Name of RO/KVS HQ)
t t tall

	the transfer (in not more than 50 words):
I, Sh./Smt./Ms./Miss_	1 1
*medical certificate and declaration furnis	do hereby to 13 of Part-B of the application is constant shed is/are bonafide (*strike off if not appliation shall render me liable for disciplinary ac
Place:	
Date:	
	(Signature of the ap
	Name
	Designation
	KVS RO/ZIET
Remarks/Recommendations for transfer (by	KVS RO/ZIET
	KVS RO/ZIET Deputy Commissioner, RO) -
	KVS RO/ZIET Deputy Commissioner, RO) -
	KVS RO/ZIET Deputy Commissioner, RO) -
	KVS RO/ZIET Deputy Commissioner, RO) -
t is certified that the information given in	KVS RO/ZIET Deputy Commissioner, RO) - the application form has been verified from
t is certified that the information given in	KVS RO/ZIET Deputy Commissioner, RO) - the application form has been verified from the application form the app
t is certified that the information given in	KVS RO/ZIET Deputy Commissioner, RO) - the application form has been verified fr (Signature)
t is certified that the information given in	KVS RO/ZIET Deputy Commissioner, RO) - the application form has been verified from (Signature) Deputy Commissioner
t is certified that the information given in	KVS RO/ZIET Deputy Commissioner, RO) - the application form has been verified from the application form the app

Certified that the details furnished bythe applicant have been verified from the service records and found correct.

(Signature)
Assistant Commissioenr (Estt.-I)
KVS(HQ), New Delhi

MEDICAL CERTIFICATE

(TO AVOID DIS	QUALIFICATION, PLEASE D	O NOT USE ABBREVIATION, FILL IN
CAPITAL LETT	ERS ONLY. PLEASE DO NOT	ATTACH ANY ENCLOSURE EXCEPT
WHERE SPECIF	ICALLY ASKED FOR)	
Name of Patient:		
Relation of the pa	tient with the employee:	
(Self/spouse/son/e	daughter)	
Address of the Do	octor	
		
	(Land Line)	
Date:	(Mobile)	
	-	
	Certifica	te
Tu .		<u></u>
I, Dr.		with Medical Council Registration
No	hereby certify that Shri/Smt./M	s./Miss/Master
aged	Gender*who	himself/herself is a KVS employee or
	fe/husband of Sh./Smt./Ms.	
(Name of KVS e	mployee) is suffering from the o	disease/diseases with the details as follows
and that treatmen	t of this disease is not at all avail	able at this station or in its vicinity (*Strike
off whichever is	not applicable).	
,	OF CARCINOMA	
	of carcinoma with site affected:	
	when it was detected first: nistory-Pathological report with re	eference No. & dates
J. DIICI I	nstory-r amological report with the	defence ivo. & dates.
	I classification (if applicable):	41-
	nces in support of uncontrolled graces in support Metastasis:	owth
	tion of neighboring or surroundin	g structures:
	nent being continued (in brief):	
9. Full na	ame of surgery/surgeries in conne	ection with dates:
	a a	
15	C.1 - D)	(0)
(Signature	of the Doctor)	(Signature of the applicant)

C) IN CASE OF RENAL FAILURE

- 1. Name of disease causing Renal failure:
- 2. Evidences in support of Chronic Irreversible changes:
- 3. Number of Dialysis done with dates:
- 4. Kidneys involved (single/both):
- 5. Any surgery including renal transplantation done (Yes/No):

C) IN CASE OF LOSS OF MUSCLE POWER

- 1. How many extremities are affected?:
- 2. Grading of muscle power at present:
- 3. Grading of muscle power at the onset of disease:
- 4. Duration of loss of muscle power:
- 5. Any recovery after the onset till date:
- 6. Most Direct cause of loss of Muscle Power:

D) <u>IN CASE OF HEART DISEASE</u>

- 1. Name of the surgical procedure undergone. CABG/Angioplasy:
- 2. Date of surgical procedure:
- 3. Name of Doctor-Surgeon:
- 4. Name of Hospital:

E) IN CASE OF THALASSEMIA

- 1. Name of disease (with specification- major or minor):
- 2. Date of first detection:
- 3. Whether blood transfusion required? (Yes/No):
- 4. If so, periodicity of duration of blood transfusion/replacement required by the patient/chelation therapy:
- 5. Blood transfusion done last: (DD/MM/YYYY)

F) IN CASE OF PARKINSON'S DISEASE

- 1. Date of detection of disease:
- 2. Duration of treatment undergone:
- 3. Date & designation of treating Neurologist:
- 4. Whether admitted in hospital & if so, details thereof:
- 5. Progressiveness of the disease- please specify: (To be certified by a neurologist)

G) IN CASE OF MOTOR - NEURON DISEASE

- 1. Date of detection of the disease:
- 2. Duration of treatment undergone:
- 3. Name & designation of the treating neurologist:
- 4. Result of EMG test report & MRI:
- 5. Grading of muscle power at present:

(The Doctor is requested to "Cross" the A/B/C/D/E/F/G above whichever is not applicable in the case of the Patient)

(Signature of the Doctor)

(Signature of the applicant)

-	
Place :	
Date :	
	(Signature of the Civil Sur
	Name
	Name of the Deptt.
	Name of the Hospital
	Seal:
Signature and name of the	
KVS employee (applicant): _	
G' (A. D.	
Signature and Name of the Pa	tient:

DECLARATION FOR WORKING SPOUSE (IN KVS/GOVT. SECTOR)

I,		(Name of employee) s	sole
declare that m	y spouse	(Name) is presently e	mpl
at	_ (Name of the station) which	is my *present station/within	100
distance of my	present station or my choice stat	ion/within 100 kms of my choice	e sta
The spouse is en	mployed in KVS/Govt. sector as	(designation	on o
spouse). His/He	r full office address with name &	& Designation of immediate super	rior
follows:			
Name and office	e address (with Pin Code) of the S	house.	
Name and office	e address (with Fin Code) of the S	spouse.	
ContactE-mail ID	(Land Line)ddress (with Pin Code) of immedi	(Mobile)	
ContactE-mail IDName & office ac Officer of the Sp	(Land Line)ddress (with Pin Code) of immedi	(Mobile) iate Superior	
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Contact- E-mail ID Name & office as Officer of the Sp Contact- E-mail ID Signature of Em Name: Designation:	(Land Line)ddress (with Pin Code) of immedicouse:(Land Line)	iate Superior (Mobile)	

Office Seal

KENDRIYA VIDYALAYA SANGATHAN

ANNUAL TRANSFER APPLICATION FOR DEPUTY COMMISSIONERS/ DIRECTORS OF REGIONAL OFFICES/ZIETs -2021-22 PART-A (MANDATORY FOR ALL)

11. Five choices in order of preference (In case of mandatory transfer in public interest): Sl. Choices of Place of Posting (Name of RO/ZIET/KVS HQ) 1.	
ii) Date of appointment in the present post (dd/mm/yyyy) 4. Present place of posting :	
ii) Date of appointment in the present post (dd/mm/yyyy) 4. Present place of posting :	
5. Date of Birth (dd/mm/yyyy) : 6. Home Town with District & State/UT (As per service records) : 7. Date of joining in the present RO (dd/mm/yyyy) : 8. Date of joining at the present : Station (dd/mm/yyyy) 9. Is spouse working (Yes/No) : If yes, Name of the Department in which spouse is working : Station where spouse is working : 10. Reason for last transfer (Tick whichever applicable and Cross whichever not applicable and Cross whichever not applicable in the present in the p	
5. Date of Birth (dd/mm/yyyy) :	
6. Home Town with District & State/UT (As per service records): 7. Date of joining in the present RO (dd/mm/yyyy): 8. Date of joining at the present : Station (dd/mm/yyyy) 9. Is spouse working (Yes/No) : If yes, Name of the Department in which spouse is working : Station where spouse is working : Station where spouse is working : 10. Reason for last transfer (Tick whichever applicable and Cross whichever not applicable in the company of the company	
7. Date of joining in the present RO (dd/mm/yyyy) :	
8. Date of joining at the present Station (dd/mm/yyyy) 9. Is spouse working (Yes/No) : If yes, Name of the Department in which spouse is working : Station where spouse is working : 10. Reason for last transfer (Tick whichever applicable and Cross whichever not applicable and Cross	
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10. Reason for last transfer (Tick whichever applicable and Cross whichever not applic	
11. Five choices in order of preference (In case of mandatory transfer in public interest): Sl. Choices of Place of Posting (Name of RO/ZIET/KVS HQ) 1.	
Sl. Choices of Place of Posting (Name of RO/ZIET/KVS HQ) 1.	IN PUBLIC ANY OTHER
1.	ransfer in public interest):
2. 3. 4. 5.	RO/ZIET/KVS HQ)
12. Details of last 03 transfers (on any post in KVS), if any. Sl. Post Name of KV/RO/ZIFT Period (Datas)	
held Control (Dates) Reason(s) for transfer out of mentioned	
1. 2.	yyyy) transfer out of the
3.	yyyy) transfer out of the mentioned

Note: To be filled in Chronological order. Details of present posting not to be filled in this table.

Place: _					
Date:					
					(Signature of the applic
				Nam	e
					gnation
					RO/ZIET
	(To be	filled up	by KVS (HQ), New	v Delhi in case of Deputy	
oardResu	dt of n	resent KV	/S DO11	tuse of Deputy	Commissioner)
plicable)	:-	resent K	S RO under the	present Deputy Comm	issioner (Write N/A if not
cademic	Pas	s %age	Qual	ity of result	T
Year	Sec.	Sr. Sec.	Secondary	Sr. Sec. level	Remarks, if any
	level	level	level(%age of examinees with 8.0 or more CGPA/75% or more aggregate marks)	(%age of examinees with 75% or more aggregate marks)	
016-17			more aggregate marks)		
017-18					
018-19					
713-20					
ike off wh		is not app			
pending	contem/	plated ao	gainst Sh./Smt./Ms.	is pending/contempla ./Miss mentioned):	ted/Disciplinary case is (in case
- -					
Certified and are for He/Shew away/pre	that the ound coras *on sently n	e details fur rrect. leave/abse ot away fre	rnished by the application of th	cant have been verified fi	com his/her service records (period). He/Sheis *still
He/Shew away/pre	sently n	ot away fr	nt/absent without page of duties.	ay during	_ (period). He/Sheis *still

KVS(HQ), New Delhi

PART-B (TO BE FILLED ONLY FOR REQUEST TRANSFER)

N	ame: (Sh./Smt./Ms./Miss) – Tick whichever applicable
	Employee Code as per UBI portal :
	i) Post held :
	ii) Date of appointment : in the present post
	Present place of posting :
	Date of Birth (dd/mm/yyyy) :
	Date of joining in the present RO/ZIET (dd/mm/yyyy) :
	Date of joining at the present: Station (dd/mm/yyyy)
	Is spouse working (Yes/No) : Name of the Deptt.in which spouse is working :
	Station where spouse is working:
	Have you given the declaration regarding the employment of spouse: (Yes/No)
	Ground for seeking transfer: (LTR/ MDG /DFP/Spouse case/Other-Specify)
. <u>I</u>	Five choice stations in order of preference (In case of transfer on own request)
	S1. Choice of place of posting {Name of RO/ZIET/KVS(HQ)}
	1.
	2.
	3. 4.
	5.
	Completion of 3 years' continuous stayat present station as on 30.06.2021 (Yes/No)

(Signature of the applicant)

Narrate the compelling ground for seeking the transfer (in approx. 50 words):
I, Sh./Smt/Ms./Miss do hereby affirm that the information given in Sl. No. 1 to 13 of Part-B of the application is correct and *medical certificate and declaration furnished is/are bonafide (*strike off if not applicable). I understand that wrong/suppressed information shall render me liable for disciplinary action.
Place:
Date: (Signature of the applicant)
Name
Designation
KV/KVS RO/ZIET
It is certified that the information given in the application form has been verified from the records and is found correct.
(Signature)

Assistant Commissioner (Estt.I)

KVS (HQ), New Delhi

MEDICAL CERTIFICATE

CAPIT WHEI	AVOID DISQUALIFICATION, PLEASE DO NOT USE FAL LETTERS ONLY. PLEASE DO NOT ATTACH A RE SPECIFICALLY ASKED FOR) of Patient:	NY ENCLOSURE EXCEPT
	on of the patient with the employee:spouse/son/daughter)	_
	ss of the Doctor	
	ct No(Land Line)(Mobile)	
	<u>Certificate</u>	
aged *son/d (Name and th	I, Dr with Mhereby certify that Shri/Smt./Ms./Miss/Master	erelf is a KVS employee or es with the details as follows
2.	Date when it was detected first:	ates:
4. 5. 6. 7. 8. 9.	T.N.M classification (if applicable): Evidences in support of uncontrolled growth Evidences in support Metastasis: Condition of neighboring or surrounding structures: Treatment being continued (in brief): Full name of surgery/surgeries in connection with dates:	
	(Signature of the Doctor)	(Signature of the applicant)

D) IN CASE OF RENAL FAILURE

- 1. Name of disease causing Renal failure:
- 2. Evidences in support of Chronic Irreversible changes:
- 3. Number of Dialysis done with dates:
- 4. Kidneys involved (single/both):
- 5. Any surgery including renal transplantation done (Yes/No):

C) IN CASE OF LOSS OF MUSCLE POWER

- 1. How many extremities are affected?:
- 2. Grading of muscle power at present:
- 3. Grading of muscle power at the onset of disease:
- 4. Duration of loss of muscle power:
- 5. Any recovery after the onset till date:
- 6. Most Direct cause of loss of Muscle Power:

D) IN CASE OF HEART DISEASE

- 1. Name of the surgical procedure undergone. CABG/Angioplasy:
- 2. Date of surgical procedure:
- 3. Name of Doctor-Surgeon:
- 4. Name of Hospital:

E) IN CASE OF THALASSEMIA

- 1. Name of disease (with specification- major or minor):
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- 3. Whether blood transfusion required? (Yes/No):
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- 5. Blood transfusion done last: (DD/MM/YYYY)

F) <u>IN CASE OF PARKINSON'S DISEASE</u>

- 1. Date of detection of disease:
- 2. Duration of treatment undergone:
- 3. Date & designation of treating Neurologist:
- 4. Whether admitted in hospital & if so, details thereof:
- 5. Progressiveness of the disease- please specify: (To be certified by a neurologist)

G) IN CASE OF MOTOR - NEURON DISEASE

- 1. Date of detection of the disease:
- 2. Duration of treatment undergone:
- 3. Name & designation of the treating neurologist
- 4. Result of EMG test report & MRI:
- 5. Grading of muscle power at present:

(The Doctor is requested to "Cross" the A/B/C/D/E/F/G above whichever is not applicable in the case of the Patient)

(Signature of the Doctor)

(Signature of the applicant)

Place :	
Date :	
	(Signature of the Civil Surgeon
	Name
	Name of the Deptt.
	Name of the Hospital
	Seal:
Signature and name	f the
KVS employee (app	cant):
	of the Patient:

DECLARATION FOR WORKING SPOUSE (IN KVS/GOVT. SECTOR)

I,		(Name of employee) solo
declare that	my spouse	(Name) is presently emp
at	(Name of the station) which is	s my *present station/within 100
distance of my	present station or my choice station	n/within 100 kms of my choice st
The spouse is a	employed in KVS/Govt. sector as	(designation
spouse). His/H	er full office address with name & I	Designation of immediate :
follows:	with malie & I	Sesignation of immediate superior
N 1 co		
	e address (with Pin Code) of the Spo	
Contact-	(I and I ina)	(Mobile)
Contact-	(I and I ina)	(Mobile)
E-mail ID	(Land Line)	
E-mail ID Name & office a	(Land Line)address (with Pin Code) of immediate	
E-mail ID Name & office a Officer of the Sp	address (with Pin Code) of immediate	e Superior
E-mail ID Name & office a Officer of the Sp	(Land Line)address (with Pin Code) of immediate	e Superior
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Contact E-mail ID Name & office a Officer of the Sp Contact E-mail ID Signature of Em	(Land Line)address (with Pin Code) of immediate pouse:(Land Line)	e Superior (Mobile)