



مدرسة أبوظبي الهندية

Abu Dhabi Indian School

E-mail: adiscbse@emirates.net.ae | Web : www.adisuae.com



P.O. Box 46492  
Abu Dhabi, U.A.E.

Tel : +9712 4488 025  
Fax : +9712 4489 002

APPLICATION FORM FOR THE POST OF \_\_\_\_\_

Latest  
photograph

A. **PERSONAL INFORMATION**

1. Name in full (Capital letters): \_\_\_\_\_  
(As per the passport)
2. Father's/Husband's Name: \_\_\_\_\_
3. Date of Birth & Applicant's:  
age on date of applying \_\_\_\_\_
4. Nationality : \_\_\_\_\_
5. Passport No : \_\_\_\_\_  
Date of Issue: \_\_\_\_\_ Date of Expiry: \_\_\_\_\_
6. Visa Status(sponsored by) : Father Husband School Visit Visa  
(Tick the correct one)
7. Details of Sponsor : Name: \_\_\_\_\_  
Tel.No.(O) : \_\_\_\_\_ (M): \_\_\_\_\_
8. Local Address : Any Change should be intimated in writing immediately  
Building Name/No.: \_\_\_\_\_  
Area : \_\_\_\_\_  
Road : \_\_\_\_\_ P.O.Box \_\_\_\_\_  
Tel.No.: (R): \_\_\_\_\_ (O): \_\_\_\_\_ (M): \_\_\_\_\_  
Email ID: \_\_\_\_\_  
Permanent Address in India: \_\_\_\_\_
9. Current Drawn Salary: \_\_\_\_\_ Expected Salary: \_\_\_\_\_
10. List of Documents to be attached (Put a tick mark on whatever applicable)
- a) Passport Copy  b) Visa Copy  c) Emirates ID Copy
- d) Degree Certificate  e) Degree Marksheet  f) PG Marksheet
- g) PG Certificate  h) B.Ed Certificate  i) B.Ed Marksheet
- j) Translation of the certificates/ marksheet if not in English or Arabic
- k) Passport Size Photograph  l) Experience Certificate  m) ADEK Approval
- n) Covid – 19 Vaccination Certificate



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**B.(i) Academic Record**

S. N.	Deg./ Dip. Cert.	Yr.of Passing	Board/ Univ.	Sub.of Specialization	Attestations From India: Home Dept/UAE Consulate Local: MOE/MOHR.Ed		Remarks
					Ind.Att. : Yes/No	MOE : Yes/No	
1.	Matriculation/Pre Univ./Sen.Sec. (XII)				Ind.Att. : Yes/No		
					MOE : Yes/No		
2.	B.A./B.Sc./ B.Com with marks Stmt.(Final)				Ind.Att. : Yes/No		
					Gen.Cert : Yes/No		
3.	M.A./M.Sc. / M.Com with Marks Stmt.(Final)				Ind.Att. : Yes/No		
					Gen.Cert : Yes/No		
4.	B.Ed./M.Ed./PG Dip/ Montessori Training from Recognized University /Institute With Marks Stmt.(Final)				Ind.Att. : Yes/No		
					Gen.Cert : Yes/No		
5	Any Other Qualification				Ind.Att. : Yes/No		
					Gen.Cert : Yes/No		

**B.(ii) Experience**

**IN INDIA**

Sl.No.	Institution's Name (in short)	From	To	Remarks	
				Subject	Class
Total No.of years of Experience					

**IN GULF**

Sl.No.	Institution's Name (in short)	From	To	Remarks	
				Subject	Class
Total No.of years of Experience					



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**B.(iii) Any Relevant Experience (Training/Workshops/Seminars Conducted/attended with supporting documents)**

Sl.No.	Name of experience	Remarks

**C. Specific activities interested in and will contribute to the school**

Sl.No.	Name of Activity	Level of Attainment	Mention what way you can contribute to the school

**D. Details of any Recognitions / Awards / Scholarships Received**

Sl.No.	Details of Recognitions / Awards / Scholarships	Remarks



### E) HEALTH PROFILE / DATA COLLECTION FORM

Name		DOB		Gender	
Address		Home/Landline no		Mobile No	
Contact Person Name:			Contact Person Mobile No:		
Health Insurance:		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Blood Group:					
Allergies: Please list any drug , food, insect bite, substance etc to which you have had an allergy or bad reaction					
Medication History					
Name of the Medicine		Dosage		Frequency	Purpose
Surgical History					
Name of the Surgery		Date/ Month/Year		Under GA/LA/Spinal Anaesthesia	
Medical Devices: Pace maker, Insulin Pump, Hearing Aids etc.					
Name of the Device		Provider		Provider Number	Date of Last Service
Known Medical Condition/ Diagnosis					
Anaemia: <input type="checkbox"/>		Arthritis: <input type="checkbox"/>		Asthma: <input type="checkbox"/>	Bleeding Disorder: <input type="checkbox"/>
Depression: <input type="checkbox"/>		Diabetis: <input type="checkbox"/>		Heart Disease: <input type="checkbox"/>	Hepatitis: <input type="checkbox"/>
Cholesterol: <input type="checkbox"/>		Kidney Disease: <input type="checkbox"/>		Liver Disease: <input type="checkbox"/>	Lung Disease: <input type="checkbox"/>
Cancer: <input type="checkbox"/>		Blood Pressure: <input type="checkbox"/>		Transplant: <input type="checkbox"/>	Other:.....
Special Needs:					
Functional/ Locomotor Impairment			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Vision Impairment			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Hearing Impairment			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Covid -19 Vaccination			Yes <input type="checkbox"/>	No <input type="checkbox"/>	



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**F. Write a few lines about yourself highlighting your Interests, Achievements & Accomplishments**


**V.V.Important:** Any entry in this form should be supported by the photocopy of the document. In the absence of documents, your claim will not be considered.

This is to declare that the information furnished above in Parts A, B, C, D, E & F by me is true to the best of my knowledge and belief.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR OFFICIAL USE**

Preliminary interview conducted by \_\_\_\_\_ on \_\_\_\_\_ Result: \_\_\_\_\_.

Interview conducted by the Education Committee on \_\_\_\_\_.

Result of interview : \_\_\_\_\_

Signature & Name of Dealing officer : \_\_\_\_\_

Appointed on \_\_\_\_\_ on probation against post of \_\_\_\_\_ in the \_\_\_\_\_ shift.

Principal