Indian Association of Palliative Care
Nomination Form for Election (2027)

(ONE CANDIDATE CAN APPLY FOR ONE POST ONLY)

Name of the candidate	
Post applied for	
IAPC Membership Number	
Joining Date IAPC	
Candidate's Contact Number	
Candidate's Email ID	

Name of the Proposer	
IAPC Membership Number of the Proposer	
Signature of the Proposer	
Date and Place	
Name of the Second Proposer	
IAPC Membership Number of the Second Proposer	
Signature of the Second Proposer	
Date and Place	

Indian Association of Palliative Care
Template for CV
(To be submitted along with Nomination Form)

***Note**:*

- *Please use Font Style: Times New Roman; Font size:12 while filling in the below details*
- *Kindly limit the CV to 600 words*
- *The CV MUST NOT include any activity related photographs or any newspaper cuttings*

Name of the Candidate	
Designation	
Institution	
Educational Qualifications	
Number of Publications	
Awards/Appreciations	
Institutional Posts held in Chronological Sequence	

Work done in Palliative care	
What will you contribute especially to the IAPC, during your tenure, if elected?	

Declaration:

1. The above-mentioned information is true to the best of my knowledge.

2. If elected, I will submit an affidavit for the purpose of the Office of Charity Commissioner declaring that I am willing to accept this post in an honorary capacity and will discharge my duties as per the Bylaws of the IAPC.

- Signature of the Candidate:
- Date:
- Place:

Note:

- The scanned copy of the signed and fully completed nomination form including CV and passport size photograph to be emailed to the Secretary, IAPC, at iapcelections@gmail.com **before** Tuesday, 5 January, 2027.

1. **Last date to submit online nomination: 5:00 p.m. Friday, 5 January, 2027.**
2. **Last date to withdraw nomination:** Friday, 19 February by 5:30 pm
3. **Election date *(if needed)*:** Saturday, 20 February, 2027
4. Late nominations and nominations submitted to any other email address will not be accepted.
5. Please write to nioiapc@gmail.com for any queries.