

Dr. Darshan Shah M.D. (psych), D.P.M.

305, SIGMA ICON 2, OPPOSITE MEDILINK HOSPITAL, SHYMAL CROSSROADS, AHMEDABAD
380015

Telephone 9824037887, Email - darshang_1@yahoo.com

CANDIDATE CONSENT DECLARATION FORM

I, Mr./Ms. _____ DO HEREBY GIVE MY CONSENT TO VOLUNTARILY UNDERGO THE EVALUATION PROCESS TO ASSESS MY CANDIDATURE AS PART OF THE JOB INTERVIEW SELECTION PROCESS FOR WHICH I AM CURRENTLY APPLYING. THE EVALUATION PROCESS HAS BEEN EXPLAINED TO ME. I WILL MAINTAIN CONFIDENTIALITY OF THE PROCESS & WILL NOT SHARE OR DISCUSS THE INFORMATION WITH ANYONE ELSE EXCEPT DR.DARSHAN SHAH & HIS ASSESSMENT TEAM. I SHALL COOPERATE DURING THE ENTIRE PROCESS & WILL ENSURE TO COMPLETE ALL THE REQUIRED ACTIVITIES AS PER THE GIVEN INSTRUCTIONS. I SHALL BE HONEST IN SHARING ALL THE INFORMATION WHICH IS REQUESTED FROM ME.

I SHALL NOT GIVE ANY FALSE/MISLEADING INFORMATION OR WITHELD ANY CRITICAL INFORMATION WHICH HAS BEEN REQUESTED DURING THE EVALUATION PROCESS. IN CASE OF ANY FALSE/ MISLEADING INFORMATION, I MAY BE DISQUALIFIED FROM THE SELECTION PROCESS.

I GIVE MY CONSENT TO SHARE THE ASSESSMENT REPORT WITH THE PLACEMENT AGENCY/ COMPANY, WHICH IS CONDUCTING THE SELECTION PROCESS. I WILL NOT HOLD YOUR FIRM/ COMPANY LIABLE FOR THE FINAL OUTCOME/ RESULTS OF THE SELECTION PROCESS.

SIGNATURE:

SIGNATURE:

NAME:

NAME:

DATE:

DATE:

PLACE:

PLACE: