**KARNTAKA STATE MENTAL HEALTH AUTHORITY**
**Chief Executive Officer and Commissioner**
**Health & Family Welfare Services**
Arogya Soudha, 4th Floor, West Wing, Magadi Road, Bengaluru.
Email:ksmha1@gmail.com, Phone Number: 080-29559040,
Website: www. ksmha.co.in

**Appointment of Chairperson and members for District Mental Health Review Boards**

Government of Karnataka constitutes five (05) District Mental Health Review Boards across the state as mandated in section 73 of Mental Health Care Act-2017, in the following location. Accordingly State Mental Health Authority invites applications for appointment to the following positions in each of the District Mental Health Review Boards from interested persons possessing the requisite qualifications.

**Chairperson:**

District Judges or officers of the State judicial Service, who are qualified to be appointed as District Judges or retired District Judges for each board.

**Other members:**

Persons with Mental illness or care-givers or non-governmental organizations working in the field of mental health (Two).

Copy of the Mental Health Care Act-2017, available in the GOI website.

Interested applicants may visit **www.karhfw.gov.in** or www.ksmha.co.in for details on eligibility conditions, application and terms and conditions.

The filled in applications, along with copies of certificates/ documents, may be submitted by post/speed post / by hand to Chief Executive Officer in the above address.

Last date for submission of application and documents is 30 -01-2021.

KARNATAKA STATE MENTAL HEALTH AUTHORITY

Photo

# Application for appointment as Chairperson/ Members to District Mental Health Review Boards

| Please tick for position applying for | | | |
|---|---|---|---|
| (a) | Chairperson | (b) | Persons with mental illness or care-givers |
| (c) | Persons representing organizations of persons with mental illness or care-givers | | |
| (d) Non-governmental organizations working in the field of mental health | | | |

| | | |
|---|---|---|
| 1. | Name | |
| 2. | Nationality | |
| 3. | Date of Birth | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 4. | Gender | | Male | | Female | | Others |

| | | | | |
|---|---|---|---|---|
| 5. | Contact Address | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | PIN CODE |
| Tel | Office | | Res | |
| | Mobile | | e-mail | |

6. Qualification:-

a. Chairperson

| Year of passing Law Degree* | Name of Institution | Name of the Bar Association | State Bar council Registration No. | Year of first posting as District Judge/ officer of state judicial Service* | Place(s) Posting* | If retired, date of retirement position, if any* |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

*copies of documents to be furnished

b. In respect of persons applying under category (b) above furnish following details

| Name of the Institution/hospital where the person have/have had treatment for mental illness* | Period | | Documents if any |
|---|---|---|---|
| | From | To | |
| | | | |
| | | | |

c. In respect of persons applying under category (d) above furnish following details

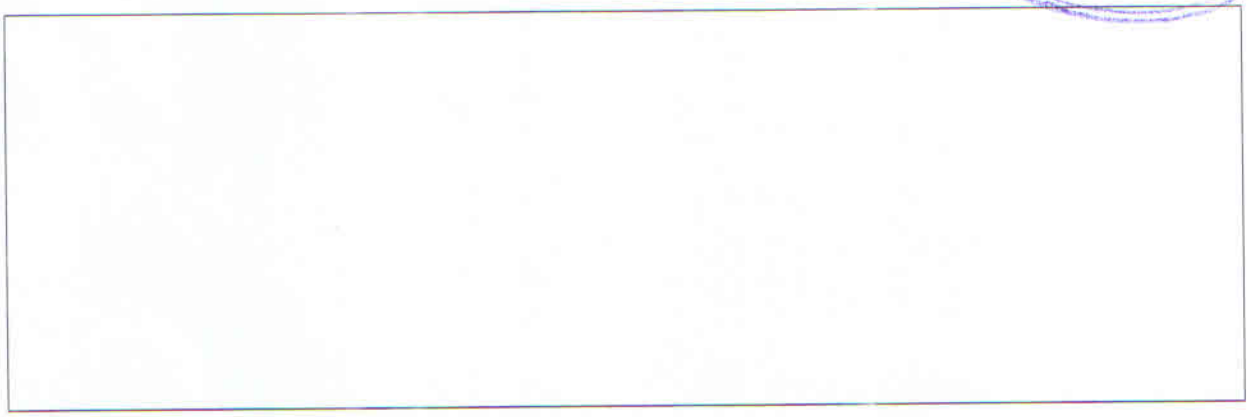
| Name of the patient to whom you are representing as care giver | Name of the Institution/hospital where the patient undergone/undergoing treatment for mental illness* | Period | | Documents if any |
|---|---|---|---|---|
| | | From | To | |
| | | | | |
| | | | | |
| | | | | |

d. In respect of persons applying under category (c) above furnish following details

| Name of the NGO & address | No. of years serving in the field of mental health | License/ Registration with any organization, if so no. & date* |
|---|---|---|
| | | |
| | | |

*copies of documents to be furnished

7. What do you consider significant about you for considering your application: Maximum 100 words

Declaration

Certificated that the information given in the application are true and complete

Place: Signature:

Date: Name: