



MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA

STATE HEALTH SERVICE ALLOCATION

Form No. 1

Name: _____
 Date: _____
 State: _____
 District: _____
 Block: _____
 Panchayat: _____

1. Name of the person: _____
2. Age: _____
3. Sex: _____
4. Education: _____
5. Occupation: _____
6. Address: _____
7. Date of birth: _____
8. Date of death: _____

Sl. No.	Age	Sex	Education	Occupation	Address
1	1	M			
2	2	M			
3	3	M			
4	4	M			
5	5	M			
6	6	M			
7	7	M			
8	8	M			
9	9	M			
10	10	M			
11	11	M			
12	12	M			
13	13	M			
14	14	M			
15	15	M			
16	16	M			
17	17	M			
18	18	M			
19	19	M			
20	20	M			
21	21	M			
22	22	M			
23	23	M			
24	24	M			
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26	26	M			
27	27	M			
28	28	M			
29	29	M			
30	30	M			
31	31	M			
32	32	M			
33	33	M			
34	34	M			
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36	36	M			
37	37	M			
38	38	M			
39	39	M			
40	40	M			
41	41	M			
42	42	M			
43	43	M			
44	44	M			
45	45	M			
46	46	M			
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51	51	M			
52	52	M			
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55	55	M			
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67	67	M			
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80	80	M			
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85	85	M			
86	86	M			
87	87	M			
88	88	M			
89	89	M			
90	90	M			
91	91	M			
92	92	M			
93	93	M			
94	94	M			
95	95	M			
96	96	M			
97	97	M			
98	98	M			
99	99	M			
100	100	M			

Total: _____

Signature: _____

Date: _____

Place: _____