**To be completed on an official letter head of the institute**

**Annexure – RP-Community Medicine**

**ROTATIONAL POSTING OF DNB TRAINEE(S) IN COMMUNITY MEDICINE:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Community Centre** | **Location(s)** | **Staff** | **OPD Attendance in last year** | **Number of Registered Families/ Patients** | **Duration of Posting** | **Supervising Consultant** |
| Rural posting at sub-center (06 months) |  |  |  |  |  |  |
| Rural posting in primary health care (06 months) |  |  |  |  |  |  |
| Urban posting in urban health institute (03 months) |  |  |  |  |  |  |

**Community Interventions/Activities (for last three years)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Intervention/ Activities** | **Purpose** | **Attendance of Patients/ Community** | **Role of DNB Trainees** | **Supervising Consultant** |
| Outreach camps |  |  |  |  |
| Mass screenings |  |  |  |  |
| Screening OPD’s |  |  |  |  |
| Continuity of Care |  |  |  |  |
| Palliative Care |  |  |  |  |
| Geriatric Care |  |  |  |  |
| Rehabilitation Services |  |  |  |  |
| Epidemiological surveys |  |  |  |  |
| Immunization camps |  |  |  |  |
| Preventive & Promotional health camps |  |  |  |  |
| Disease Surveillance |  |  |  |  |
| National Health Programme |  |  |  |  |

**Work attachment**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital/Office** | **Objectives** | **Name of address of office/hospital for work attachment** | **Supervising Consultant Name/Officer** |
| District Health Office (03 months) | RCH,  School Health,  Communicable disease,  Statistical unit  IEC Cell |  |  |
| Directorate of Health ( 03 months | Planning & Evaluation Cell,  Programme Management (RCH, CD, Vital states) |  |  |
| Secondary/tertiary level hospital ( 03 months) | Stores management,  Waste Management  Personal management |  |  |

It is herewith certified that DNB trainees are/shall be rotated in all of the above disciplines as per the prescribed DNB Community Medicine curriculum.

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| --- | --- |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Signatures of Head of the Department/ Course Director with stamp** | **Signature with official stamp of Administrative Head of the Institute/Hospital**  (Authorized signatory on behalf of applicant hospital) |