**Information in below mentioned table is required to be filled by NBE appointed Assessor only:**

|  |  |  |
| --- | --- | --- |
| **Name of the Hospital/Institute** |  | |
| **Assessment conducted for the Programme of** |  | |
| **Date of Assessment** |  | |
| **Proposed Faculty is Accepted for aforesaid Programme as** | ***Eligibility as per NBE norms*** | **Mark √for Acceptability** |
| *Senior Consultant* |  |
| *Junior Consultant* |  |
| *Senior Resident* |  |
| *Not Accepted* |  |
| **Name of the Assessor** |  | |
| **Signature of Assessor** |  | |

**DECLARATION FORM – FACULTY/SENIOR RESIDENTS**

* It shall be the responsibility of Head of the Institute and designated Head of the Applicant Department that faculty declarations are completed and submitted only for those faculty in the department who are employed on “FULL TIME” basis. Please do not submit faculty declarations for Part time/Visiting/Adjunct faculty in the department.
* The maximum eligible age to qualify as faculty for DNB/FNB programme, at the time of application submission, is 75 years. Please ensure that faculty declarations are not completed & submitted for faculty who have attained an age of 75 years at the time of application submission.
* The proposed faculty shall be in possession of minimum eligible qualifications as prescribed by NBE which is duly recognized as per provisions of IMC act.

Faculty Declaration for seeking NBE Accreditation in the specialty of \_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Hospital / Institute).

**PERSONAL INFORMATION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1.** | Name of the faculty: |  | | **Photo** |
| **2.** | Designation in the applicant hospital/Institute: |  | |
| **3.** | Date of Birth (DD-MM-YYYY): |  | |
| **4.** | PAN Number: |  | |
| **5.** | Faculty Eligibility as per NBE norms: |  | |
| **6.** | Photo ID Proof issued by Government Authorities PAN Card/Adhaar Card/Passport etc. | **Photo ID** | **Photo ID Number** | **Issuing Authority** |
|  |  |  |
| **7.** | Present Residential Address of Faculty: |  | | |
| **8.** | Permanent Residential Address of Faculty: |  | | |

1. **Contact Particular**

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| --- | --- | --- | --- |
| **Telephone (Office) (With STD Code)** | **Mobile Number** | **Alternate Mobile Number** | **Email ID** |
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1. **PROFESSIONAL QUALIFICATIONS (In Chronological Order MBBS onwards):**

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| --- | --- | --- | --- | --- | --- | --- |
| **Course Name (eg. MBBS, DNB/MD/MS/ DM/ MCh etc.)** | **Area of specialization** | **Year of Passing** | **Name of the Medical College/Hospital/Institute with City & State** | **Qualification Registration Number** | **Name of the Medical Council** | **Registration Valid upto (month & Year)** |
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1. **EXPERIENCE AFTER PG DEGREE QUALIFICATION**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Post PG Degree Experience (in Years): | | | | |  | | | | |
| **Period of Employment Present/Past** | | | **Designation Held** | **Hospital/Institute Name with City &State** | | **Department** | **Employment Status** | **Hours Spent per Day (approx.)** | **Whether associated with DNB/FNB programme** |
| **Present/ Past** | **From (Month-Year)** | **To (Month-year)** |
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Before joining present institution, I was working at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and relieved on \_\_\_\_\_\_\_\_\_ (dd-mm-yyyy) after resignation /retiring .

1. **Research Activities of Faculty:**

(Details of maximum 5 latest Research Activities)

|  |  |
| --- | --- |
| **Research Publication *(Vancouver citation style)*** | **Nature of Research Activities** |
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**Presentation (Paper / Poster):**

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| --- | --- | --- | --- | --- |
| **Name of Presenter** | **Title of the Presentation** | **Date of Presentation** | **Name of Conference** | **Nature of Presentation** |
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1. **FACULTY AS THESIS GUIDE:**

(Details of Maximum 5 Thesis guided by the faculty. Please do not include details of thesis wherein faculty acted as a Co-Guide)

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| --- | --- | --- | --- | --- | --- |
| **Course** | **Specialty** | **Name of the Candidate** | **Thesis Topic** | **Period of Thesis Guidance in Year** | **Year of Thesis Acceptance** |
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1. **Please indicate experience of faculty in conducting Theory/Practical Examinations and Accreditation Assessment of hospitals for NBE and other Universities. (Maximum in 1000 characters):**

|  |
| --- |
|  |

1. **Please indicate significant contributions of faculty to academic activities of NBE or other universities in earlier years: (Maximum in 1000 characters)**

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1. **The faculty has drawn total emoluments from the applicant hospital / institute in current financial year as under:**

|  |  |  |
| --- | --- | --- |
| **Month & Year** | **Remuneration drawn from the Applicant Hospital / Institute** | **TDS** |
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**I hereby declare that:**

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| --- |
| 1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am working as \_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the department of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Hospital / Institute) and do hereby undertake that I am a full-time faculty at above mentioned hospital / institute and working from\_\_\_\_ AM to \_\_\_\_ PM daily at this hospital / institute. 2. I have not presented myself as faculty to any other hospital / institute / medical college concurrently for the purpose of NBE/MCI/any other accreditation for any academic programme. 3. I am not having Private Practice anywhere, OR   I am practicing at \_\_\_\_\_\_\_\_\_\_\_\_\_ (Address of Private Practice) in the city of \_\_\_\_\_\_\_\_\_ in an independent set up. My hours of private practice are \_\_\_\_\_ to \_\_\_\_\_.   1. It is also to confirm that the above-mentioned department at this Institution/ Hospital is my principle place of practice and I have no other institutional attachment / affiliation (except my own private practice in a non-academic independent setup, if so, indicated above.). Further, I have not proposed / applied / counted as a faculty for any other DNB / MD / MS / Diploma / DM / MCh / Equivalent programme in this hospital / institute or any other hospital concurrently. 2. Further, I state that I am not working in any hospital / institute other than the applicant hospital / institute in any capacity viz Regular / Contractual / Adhoc / Full time / Part time / Honorary etc. 3. Complete details with regard to work experience have been provided and nothing has been concealed by me. 4. It is declared that each statement and/or contents of this declaration and/or documents, certificate submitted along with declaration form, by the undersigned are absolutely true, correct and authentic. 5. In the event of any statement made in this declaration subsequently turning out to be incorrect or false, the undersigned has understood and accepted that such misdeclaration in respect to any content of this declaration shall also be treated as a gross misconduct thereby rendering the undersigned liable for necessary disciplinary action (including removal of name from Indian Medical Register). 6. I have gone through the Information Bulletin for Accreditation with NBE and hereby agrees to impart DNB/FNB training to DNB/FNB trainees as per prescribed NBE guidelines. |
|  |
| |  |  | | --- | --- | | **Date:   Place:** | **Signature of the Faculty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Name of the Faculty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **ENCLOSURES**  *(Following documents are required to be provided to NBE appointed Assessor at the time of assessment)*   |  |  |  | | --- | --- | --- | | **Sl No.** | **Documents** | **Submitted** | |  | Recent Passport size photo of the faculty, signed by HOI of Hospital/Institute/Medical College | **Yes / No** | |  | Photo ID proof issued by Government Authorities: Passport/PAN Card/Voter ID card/Aadhar Card | **Yes / No** | |  | Certified copies of present appointment order at present Hospital/Institute/Medical College | **Yes / No** | |  | Copy of Passport/Voter ID/ Electricity Bill/Telephone Bill/Aadhar Card as proof of present residence | **Yes / No** | |  | Joining Report at the present hospital/institute | **Yes / No** | |  | Copy of Degree Certificates of eligible PG Degree qualification | **Yes / No** | |  | Copy of Additional Qualification Registration Certificate for eligible PG Degree qualification | **Yes / No** | |  | PAN card | **Yes / No** | |  | Form 16/16A issued by the applicant hospital for AY 2019-20 (download from the website of TRACES)  Only in case of faculty joining the applicant hospital after March 2019, please submit Statement of bank transfer since joining till date | **Yes / No** |   **Signature of Faculty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ENDORSEMENT BY HEAD OF THE DEPARTMENT & HEAD OF THE INSTITUTE:**   |  | | --- | | This endorsement is the certification that the undersigned has satisfied himself / herself about the correctness and veracity of each content of this declaration and endorse the above mentioned declaration as true and correct. I have verified the certificates/documents submitted by the faculty with original certificate/documents as submitted by the faculty to the hospital / institute / medical college and found them to the correct and authentic.  I also confirm that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is not practicing or carrying out any other activity during hospital / institution / medical college working hours i.e. from \_\_\_\_\_AM to \_\_\_\_ PM since he / she has joined the institute.  The faculty has undertaken that He/She is not working at any hospital / institute other than this hospital and other than his/her private practice in an independent setup.  In the event of this declaration turning out to be either incorrect or any part of this declaration subsequently turning out be incorrect or false it is understood and accepted that the undersigned shall also be equally responsible beside the declarant himself / herself for any such misdeclaration of misstatement. | |
| |  |  |  | | --- | --- | --- | | **Signature of Head of the Department** |  | **Signature of Head of the Institute with official Stamp**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  S**igned & Verified by NBE Appointed Assessor** | |