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|  | **Specialty Specific Application Form****For Secondary Hospital****DNB – Dermatology, Venereology, and Leprosy** |
| 1. **This Specialty Specific Application Form has been designed for filling up the data / information related to SECONDARY INSTITUTE / HOSPITAL only under the Joint Accreditation Scheme**
2. **However, the information related to IPD, OPD, Case Mix/Spectrum of Diagnosis, Surgical case load have to be filled up for both Primary & Secondary Hospital in the separate tables given in this application form.**
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 **General Information of Applicant Department**

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| **1.** | **GENERAL INFORMATION OF THE DEPARTMENT FOR WHICH ACCREDITATION IS BEING SOUGHT** |
| **1.1.** | Unique Online Application Registration ID |  |
| **1.2.** | Nature of Application |  |
| **1.3.** | Name of the Specialty |  |
| Number of DNB - Dermatology, Venereology and Leprosy Seats applied for*(Specialties wherein NBEMS administers Post Diploma DNB Programme also, equal number of DNB- Post MBBS and DNB- Post Diploma candidate(s) will be allotted. For example, if accreditation is granted for 2 seats, 2 DNB Post MBBS Candidates and 2 DNB Post Diploma Candidates shall be allotted.)* |  |
| Whether the hospital is running any parallel academic programme of similar nature (in affiliation with other universities/organization) for 2-3 years (or more) duration |  |
|  | Yes/No | **If yes:** |  |
| Programm e Name | Programm e Duration (in year) |
|  |  |  |
| **1.4.** | Name of Applicant Institution / Hospital |  |
| **1.5.** | Address of the Institution / Hospital |  |
| **1.6.** | Name of the Parent Company (as per RoC/ Trust / Society / Charity) running the hospital / institute) |  |
| **1.7.** | Head of the Department / Course Director |

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| Name | Mobile Number | Email ID |
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 **Infrastructure in the Department**

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| **2.1.** | **BEDS IN THE APPLICANT DEPARTMENT** |
|  | Total Operational Beds in the Applicant Department | Number of General Beds \* in the Applicant Department |
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\* **General Beds:** General Beds are those *'earmarked'* beds/cases whose patients shall be accessible at all times for supervised clinical work to DNB trainees. Data of patients admitted on such beds or such cases shall be accessible to DNB trainees for research purposes subject to applicable ethical guidelines and clearances from institutional Ethics Committee & institutional policies. As per NBEMS norms, at least 30% beds should be allocated.

 **Patient Load**

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| **3.** | **PATIENT LOAD IN THE SPECIALTY** |
| **3.1.** | **IPD Admissions in the Applicant Department (Exclusively for DERMATOLOGY, VENEREOLOGY AND LEPROSY)** |
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| **IPD details of SECONDARY HOSPITAL ONLY** |
| Year | Total Number of Patient admitted in the department | Total Number of General\* Patient admitted in the department |
| 2022 |  |  |
| 2021 |  |  |
| 2020 |  |  |

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| **IPD details of PRIMARY HOSPITAL ONLY** |
| Year | Total Number of Patient admitted in the department | Total Number of General\* Patient admitted in the department |
| 2022 |  |  |
| 2021 |  |  |
| 2020 |  |  |

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| **3.2.** | **OPD Registration by the Applicant Department (Exclusively for DERMATOLOGY, VENEREOLOGY AND LEPROSY)** |
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|  **OPD details of SECONDARY HOSPITAL ONLY** |
| Year | Total Number of Patients registered by the department | Total Number of General\* Patient registered by the department |
| 2022 |  |  |
| 2021 |  |  |
| 2020 |  |  |

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| **OPD details of PRIMARY HOSPITAL ONLY** |
| Year | Total Number of Patients registered by the department | Total Number of General\* Patient registered by the department |
| 2022 |  |  |
| 2021 |  |  |
| 2020 |  |  |

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| **3.3.** | **SPECIAL CLINICS***Name of special clinics (as relevant to the specialty) and the number of times the clinic is held in a week.* |
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| Name of Clinics | No. of times per week | Total number of cases seen last year |
| Leprosy Clinic |  |  |
| STD Clinic |  |  |
| Dermatosurgery Clinic |  |  |
| Psoriasis Clinic |  |  |
| Pigmentation Clinic |  |  |

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**Academic Facilities & Infrastructure**

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| **4.** | **ACADEMIC FACILITIES & INFRASTRUCTURE** |
| **4.1.** | Number of Books available for DNB - Dermatology, Venereology and Leprosy Programme in the Hospital/Institute Library |  |
| **4.2.** | Details of Journals subscribed for DNB - Dermatology, Venereology and Leprosy trainees |
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| Catego ry | Title of the Journal | Versio n | Publisher Details | Date of Subscr iption | Validit y up to (Year) |
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| **4.3.** | **Rotational Posting of Trainees***DNB - Dermatology, Venereology and Leprosy trainees should be rotated / posted in different modalities / departments / areas / OTs such that exposure as prescribed can be ensured.* |
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|  | Department / Area of Rotation | Tentative schedule**(In Days OR Month(s))** | Name & Address of the institute / hospitalwhere trainees are posted for rotation | Supervising Consultant Name |  |
| **CLINICS** |
| WARD | 6 MONTHS |  |  |
| STD CLINIC | 6 MONTHS |  |  |
| LEPROSY CLINIC | 3 MONTHS |  |  |
| MINOR OT | 3 MONTHS |  |  |
| OPD | 18 MONTHS |  |  |
|  |  | **SPECIAL CLINICS (ONCE A WEEK):** |  |
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|  | VITILIGO CLINIC | 3 MONTHS |  |  |  |
| PSORIASIS CLINIC | 3 MONTHS |  |  |
| VESICO BULLOUS CLINIC | 3 MONTHS |  |  |
| PIGMENTARY CLINIC | 3 MONTHS |  |  |
| PSORIASIS CLINIC | 3 MONTHS |  |  |
| DERMATOSURGERY | 3 MONTHS |  |  |
| PHOTOTHERAPY | 3 MONTHS |  |  |
| COSMETOLOGY (PEELS, FILLERS ETC.) | 3 MONTHS |  |  |
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| Certified copy of MoU with other NBEMS accredited institute / hospital or medical college where DNB - Dermatology, Venereology and Leprosy trainees are posted for any of the above rotations, if the same is not feasible within the institute/hospital is required to be enclosed with hard copy of Specialty Specific Application which is to be submitted to NBEMS. |

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**Full Time Faculty/Staff**

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| **5.1.** | **FULL TIME STAFF IN THE APPLICANT DEPARTMENT*****(Please refer Information Bulletin for Accreditation for details of Minimum Faculty requirements)*** |
|  | Faculty declaration form for the faculty in Secondary Hospital & all their supportive documents related to the full time status of faculty must be filled and uploaded on the same web page where the faculty details of Primary Hospital / Institution have been submitted on Online Application Form. |

**Academic Sessions & Track Record**

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| **6.1.**  | **TRACK RECORD OF DNB - Dermatology, Venereology and Leprosy TRAINEES IN FINAL / EXIT EXAMINATIONS CONDUCTED BY NBEMS:** |
| **PLEASE PROVIDE THE DETAILS OF LAST 5 YEARS ONLY** |
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| Training Status of Candidate | Name of the Candidate | NBEMSRegistration Number | Year in which last appeared for Final / Exit Examinations | Year for Thesis Acceptance**(Applicable for DNB Programme only)** | Result |
| Theory | Practical |
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|  | **SINCE GRANT OF FIRST ACCREDITATION TO THE APPLICANT DEPARTMENT:** |
| a. | How many DNB - \_\_\_\_\_\_\_\_\_Trainees have been registered in the department? |  |
| b. | How many DNB - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Trainees have completed their training? |  |
| c. | How many DNB - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Trainees have qualified their Final / Exit Exams? |  |
| **DECLARATION:**I, , am duly authorized to act for and on behalf of **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** acting in my official capacity as for submitting the application of Accreditation for DNB - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for the year \_\_\_\_\_\_\_\_\_\_\_\_. I, do hereby undertake and declare that:1. I am competent to make this submission regarding the application for seeking accreditation in DNB - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to National Board of Examinations in Medical Sciences
2. The facts stated in this application are correct and based on official records and I shall be liable for any wrong or incorrect data/information submitted.
3. This hospital / institute has understood the terms, conditions, instructions, minimum accreditation criteria etc. indicated in the Information bulletin for accreditation and agree to abide by the same.
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| **Date:****Place:** |
| **Secondary Hospital / Institute****Signature with official stamp of Administrative Head of the****Secondary Institute/Hospital**(Authorized signatory on behalf of Secondary hospital)**Name:** **Designation:**  | **Primary Applicant Hospital / Institute****Signature with official stamp of Administrative Head of the****Primary Institute/Hospital**(Authorized signatory on behalf of Primary applicant hospital)**Name:** **Designation:**  |