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|  | **Specialty Specific Application Form**  **For Secondary Hospital**  **DNB – Family Medicine** |
| 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.** | |

**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 - Family Medicine Seats applied for |  |
| 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 |  |
| **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 | |  |  |  | | --- | --- | --- | | Name | Mobile Number | Email ID | |  |  |  | |

**Infrastructure in the Department**

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| **2.1.** | **BEDS IN THE APPLICANT DEPARTMENT** |
| |  |  |  |  | | --- | --- | --- | --- | |  | ALLIED SPECIALTIES | Indoor Beds in the Specialty | General beds in the Specialty\* | | General Medicine |  |  | | General Surgery |  |  | | Obstetrics and Gynaecology |  |  | | Paediatrics |  |  |   \* **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.** | **Patient Load in the Allied Specialty Departments** |
|  | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **IPD & OPD details of SECONDARY HOSPITAL ONLY** | | | | | | | | | | ALLIE D SPECI ALTIE S | OPD in Last Two Year | | General OPD in Last Two Year\* | | IPD in Last Two Year | | General IPD in Last Two Year\* | | | For the Year | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | | Genera l  Medici ne |  |  |  |  |  |  |  |  | | Genera l Surgery |  |  |  |  |  |  |  |  | | Obstet rics  and  Gynae cology |  |  |  |  |  |  |  |  | | Paedia trics |  |  |  |  |  |  |  |  | |

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| **IPD & OPD details of PRIMARY HOSPITAL ONLY** | | | | | | | | |
| ALLIE D SPECI ALTIE S | OPD in Last Two Year | | General OPD in Last Two Year\* | | IPD in Last Two Year | | General IPD in Last Two Year\* | |
| For the Year | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 |
| Genera l  Medici ne |  |  |  |  |  |  |  |  |
| Genera l Surgery |  |  |  |  |  |  |  |  |
| Obstet rics  and  Gynae cology |  |  |  |  |  |  |  |  |
| Paedia trics |  |  |  |  |  |  |  |  |

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| **3.2.** | **SPECIAL CLINICS**  *Name of special clinics (as relevant to the specialty) and the number of times the clinic is held in a week.* |
|  | |  |  |  | | --- | --- | --- | | Name of Clinics | No. of times per week | Total number of cases seen last year | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |

**Academic Facilities & Infrastructure**

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| **4.** | **ACADEMIC FACILITIES & INFRASTRUCTURE** | | | | | |
| **4.1.** | Number of Books available for DNB - Family Medicine Programme in the Hospital/Institute Library | | |  | | |
| **4.2.** | Details of Journals subscribed for DNB - Family Medicine trainees | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Category | Title of the Journal | Version | Publisher Details | Date of Subscripti on | Validity up to (Year) | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | | | | | | |
| **4.3.** | **Rotational Posting of Trainees**  *DNB - Family Medicine trainees should be rotated / posted in different modalities / departments / areas / OTs such that exposure as prescribed can be ensured.* | | | | | |
|  | | | | | |
|  | Department / Area of Rotation | Tentative schedule  **(In Days OR Month(s))** | Name & Address of the institute / hospital  where trainees are posted for rotation | Supervising Consultant Name |  |
| General medicine and allied medical  specialties including dermatology and psychiatry | 9 months |  |  |
| Pediatrics including neonatology | 6 months |  |  |
| Obstetrics and gynecology | 6 months |  |  |
| Surgery and allied  specialties including Anesthesia, ENT, | 6 months |  |  |
|  |  | Orthopedics and Ophthalmology |  |  |  |  |
|  |  | Family Practice | 6 months |  |  |  |
|  |  | Emergency medicine | 1 month |  |  |  |
|  |  | Electives | 2 months |  |  |  |
|  |  | Certified copy of MoU with other NBEMS accredited institute / hospital or medical college where DNB - Family Medicine 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. | | | |  |

**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 - Family Medicine TRAINEES IN FINAL / EXIT EXAMINATIONS CONDUCTED BY NBEMS:** | |
| **PLEASE PROVIDE THE DETAILS OF LAST 5 YEARS ONLY** | |
|  | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Training Status of Candidate | Name of the Candidate | NBEMS  Registration Number | Year in which last appeared for Final / Exit Examinations | Year for Thesis Acceptance  **(Applicable for DNB Programme only)** | Result | | | Theory | Practical | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | | |
|  | **SINCE GRANT OF FIRST ACCREDITATION TO THE APPLICANT DEPARTMENT:** | |
| a. | How many DNB - Family Medicine Trainees have been registered in the department? |  |
| b. | How many DNB - Family Medicine Trainees have completed their training? |  |
| c. | How many DNB - Family Medicine 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:** |