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|  | Specialty Specific Application Form  For Secondary Hospital  DNB – Forensic 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 - Forensic 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 | |  |  |  | | --- | --- | --- | | 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 | |  |  |  | | --- | --- | --- | | Name | Mobile Number | Email ID | |  |  |  | |

 Infrastructure in the Department

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| **2** | **BEDS IN THE APPLICANT DEPARTMENT** |
|  | Details of Beds are not required for the application of DNB - Forensic Medicine. |

 Patient Load

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| **3.** | **PATIENT LOAD IN THE SPECIALTY** |
| **3.1.** | Surgical Procedures: |
|  | |  |  |  |  | | --- | --- | --- | --- | | **Surgical Procedures of SECONDARY HOSPITAL ONLY** | | | | | Surgeries / Procedures Performed by the Department | Year Wise No. of Surgical Procedures | | | | 2022 | 2021 | 2020 | | Total number of Medico-legal autopsies |  |  |  | | Total number of Pathological autopsies |  |  |  | | Total number of Victims examined of sexual offences |  |  |  | | Total number of accused examined of sexual offences |  |  |  | | Total number of age estimation of sexual offences |  |  |  | | Total number of pregnancy certification of sexual offences |  |  |  | | **Any other Surgical Procedures that are not listed above** | | |  | |
|  | |  |  |  |  | | --- | --- | --- | --- | | **Surgical Procedures of PRIMARY HOSPITAL ONLY** | | | | | Surgeries / Procedures Performed by the Department | Year Wise No. of Surgical Procedures | | | | 2022 | 2021 | 2020 | | Total number of Medico-legal autopsies |  |  |  | | Total number of Pathological autopsies |  |  |  | | Total number of Victims examined of sexual offences |  |  |  | | Total number of accused examined of sexual offences |  |  |  | | Total number of age estimation of sexual offences |  |  |  | | Total number of pregnancy certification of sexual offences |  |  |  | | **Any other Surgical Procedures that are not listed above** | | |  | |
| **3.2.** | **Details of Clinical / Surgical procedures performed by the Department of Forensic Medicine** |
| I. | Operative Load in the specialty (during the last three years) |
|  | |  |  |  |  | | --- | --- | --- | --- | | Particulars | Year | | | | 2022 | 2021 | 2020 | | Total Number of Major Surgeries |  |  |  | | Total Number of Minor Surgeries |  |  |  | |

* 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 - Forensic 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 - Forensic Medicine Trainees have been registered in the department? |  |
| b. | How many DNB - Forensic Medicine Trainees have completed their training? |  |
| c. | How many DNB - Forensic 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:** |