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|  | Specialty Specific Application Form  For Secondary Hospital  DNB – Hospital Administration |
| 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 - Hospital Administration 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 |  |

 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 - Hospital Administration. |

 Patient Load

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| **3.** | **PATIENT LOAD IN THE SPECIALTY** |
| **3.1.** | FACILITIES AVAILABLE IN THE HOSPITAL |
|  | facilities Yes/No  Emergency Services  ICU services    Nursing Units  Operation Theatre    Medical Stores    Billing Department    CSSD    PR Department    Ambulance services    Kitchen  Incinerator  Laundry services    Support Services    Imaging Modalities |

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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 - Hospital Administration Programme in the Hospital/Institute Library | | |  | | |
| **4.2.** | Details of Journals subscribed for DNB - Hospital Administration trainees | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Category | Title of the Journal | Version | Publisher Details | Date of Subscripti on | Validity up to (Year) | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | | | | | | |
| **4.3.** | **Rotational Posting of Trainees**  *DNB - Hospital Administration 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  / hospital where trainees are posted for rotation | Supervising  Consultant Name |  |
| ER and Ambulance Services | 4 Months |  |  |  |
| ICU | 4 Months |  |  |  |
| Nursing Units | 8 Months |  |  |  |
| Operation Theatres | 4 Months |  |  |  |
|  |  | Medical Stores | 4 Months |  |  |  |
|  |  | Billing Department | 2 Months |  |  |  |
| CSSD | 2 Months |  |  |  |
| PR Department | 2 Months |  |  |  |
| Imaging Services | 2 Months |  |  |  |
| Kitchen | 2 Months |  |  |  |
| Mortuary and Other Services | 2 Months |  |  |  |
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|  | Certified copy of MoU with other NBEMS accredited institute / hospital or medical college where DNB - Hospital Administration 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 - Hospital Administration 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 - Hospital Administration Trainees have been registered in the department? |  |
| b. | How many DNB - Hospital Administration Trainees have completed their training? |  |
| c. | How many DNB - Hospital Administration 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:** |