|  |  |
| --- | --- |
|  | Specialty Specific Application FormFor Secondary HospitalDNB – 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

|  |  |
| --- | --- |
| **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

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

 Patient Load

|  |  |
| --- | --- |
| **3.** | **PATIENT LOAD IN THE SPECIALTY** |
| **3.1.** | FACILITIES AVAILABLE IN THE HOSPITAL |
|  | facilities Yes/NoEmergency ServicesICU services Nursing Units Operation Theatre Medical Stores Billing Department CSSD PR Department Ambulance services KitchenIncineratorLaundry services Support Services Imaging Modalities  |

|  |  |
| --- | --- |
| **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

|  |  |
| --- | --- |
| **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.* |
|  |
|  | Department / Area of Rotation | Tentative schedule**(In Days OR Month(s))** | Name & Address of the institute/ hospital where trainees are posted for rotation | SupervisingConsultant 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 |  |  |  |
|  |
|  | 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

|  |  |
| --- | --- |
| **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

|  |  |
| --- | --- |
| **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 | NBEMSRegistration 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.
 |

|  |
| --- |
| **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:**  |