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|  | **Specialty Specific Application Form**  **For Secondary Hospital**  **DNB – Physiology** |
| 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 |  |
| 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:** | | | Programme Name | Programme 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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| **2.1.** | **LABORATORIES IN THE SPECIALTY** | |
|  | Details of Laboratory in the hospital | |
| Laboratory | Equipment & Facilities |
|  | Clinical Physiology Lab |  |
| Hematology Lab |  |
| Amphibian Lab |  |
| Mammalian Lab |  |

 **Patient Load**

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| **3.** | **PATIENT LOAD IN THE SPECIALTY** |
| **3.1.** | Clinical Physiology Services |
|  | |  |  |  | | --- | --- | --- | | **Clinical Physiology Services of SECONDARY HOSPITAL ONLY** | | | | Specialty Services | Year wise case load in Specialty Services | | | 2022 | 2021 | | Cardiology services (ECG, Heart Rate Variability (Computerized machine), Hand Grip Dynamometer, non-invasive BP Recorder) |  |  | | Respiratory Services (Computerized Spirometry, PFTs, Peak Flow Meter, BMR etc.) |  |  | | Autonomic Function Tests |  |  | | Neurology Services (EEG, Nerve Conduction Studies, Evoked Potential Studies, VEP, BERA etc) |  |  | | Investigative facilities like Nerve conduction, EMG etc. |  |  | | Other special diagnostic facilities being provided by the department |  |  |      |  |  |  | | --- | --- | --- | | **Clinical Physiology Services of PRIMARY HOSPITAL ONLY** | | | | Specialty Services | Year wise case load in Specialty Services | | | 2022 | 2021 | | Cardiology services (ECG, Heart Rate Variability (Computerized machine), Hand Grip Dynamometer, non-invasive BP Recorder) |  |  | | Respiratory Services (Computerized Spirometry, PFTs, Peak Flow Meter, BMR etc.) |  |  | | Autonomic Function Tests |  |  | | Neurology Services (EEG, Nerve Conduction Studies, Evoked Potential Studies, VEP, BERA etc) |  |  | | Investigative facilities like Nerve conduction, EMG etc. |  |  | | Other special diagnostic facilities being provided by the department |  |  | |

 **Academic Facilities & Infrastructure**

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| **4.** | **ACADEMIC FACILITIES & INFRASTRUCTURE** | | | | | |
| **4.1.** | Number of Books available for DNB - Physiology Programme in the Hospital/Institute Library | | |  | | |
| **4.2.** | Details of Journals subscribed for DNB - Physiology trainees | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Category | Title of the Journal | Version | Publisher Details | Date of Subscripti on | Validity up to (Year) | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | | | | | | |
| **4.3.** | **Rotational Posting of Trainees**  *DNB -*  Physiology  *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 |  |
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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 - Physiology 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 - Physiology Trainees have been registered in the department? |  |
| b. | How many DNB - Physiology Trainees have completed their training? |  |
| c. | How many DNB - Physiology 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:** |