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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.**
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 **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 |

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| Yes/No | **If yes:** |
| Programme Name | Programme Duration (in year) |
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| **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 |

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| Name | Mobile Number | Email ID |
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 **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 |
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| **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 |  |  |

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| **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 |  |  |

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 **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 |
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| Category | Title of the Journal | Version | Publisher Details | Date of Subscripti on | Validity up to (Year) |
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| **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.* |
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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 | SupervisingConsultant 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** |
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| 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 |
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|  | **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:**  |