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|  | **Specialty Specific Application Form**  **For Secondary Hospital**  **DNB – Radio Diagnosis** |
| 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.** | **BEDS IN THE APPLICANT DEPARTMENT** | |
|  | Total Operational Beds in the Applicant Department | Number of General Beds \* in the Applicant Department |
| Details of Beds are not required for the application of DNB - Radio Diagnosis. | |

\* **General Beds:** General Beds are those *'earmarked'* beds/cases whose patients shall be accessible at all times for supervised clinical work to DNB trainees. Data of patients admitted on such beds or such cases shall be accessible to DNB trainees for research purposes subject to applicable ethical guidelines and clearances from institutional Ethics Committee & institutional policies. As per NBEMS norms, at least 30% beds should be allocated.

**Patient Load**



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| --- | --- | --- | --- | --- | --- |
| **3.** | **PATIENT LOAD IN THE SPECIALTY** | | | | |
| **3.1.** | Modalities Available in Radiology Department with Respective Case Load  *(Please note that, below mentioned template for modalities in Radiology Department has been taken from the details given in online MAIN APPLICATION of this year by your hospital. Any modification attempted on this page shall also be reflected in the Main application as well.)* | | | | |
|  | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | |  |  |  | If the Imaging modality | | is | |  | Equipment | |  | Whether |  | outsourced, please specify | | the | |  |  | | Whether | installed |  | following: | |  | | Supprotiv e Services |  | | Owned OR  Outsource d | Within Campus OR  outside campus | Case load in year 2022 |  | |  | | Availab ility (in number s) | Specifi cations | Name &  Address of the Outsourced Institute /  Agency | Validity MoU | of |   X RAY  Ultrasound  Machines  Color Doppler  Spiral/ Multi Slice CT  MRI  Cath Lab/ Invasive Radiology facilities  Fluroscopy  Mammography |  |  |  |  |

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| **3.2.** | Case Mix/Spectrum of Diagnosis Available in the Specialty: | | | | | |
|  |  | | | | | |
|  | **Case Mix/Spectrum of Diagnosis of SECONDARY HOSPITAL ONLY** | | | |  |
|  |
|  | Case Mix / Spectrum of Clinical/Surgical Diagnosis | Year Wise No. of Clinical Cases/ Surgical Procedures | | |
| 2022 | 2021 | 2020 |
| Orthopaedics |  |  |  |
| Obstetrics |  |  |  |
| Gynaecology |  |  |  |
| Pediatrics |  |  |  |
| General Medicine |  |  |  |
| General Surgery |  |  |  |
| Respiratory Disease/ Pulmonology |  |  |  |
|  | Neurology |  |  |  |  |
| Neuro Surgery |  |  |  |
| Urology |  |  |  |  |
| Cardiology |  |  |  |  |
| Nephrology |  |  |  |  |
| Gastroenterology |  |  |  |  |
| Oncology |  |  |  |  |
| Others |  |  |  |  |
| **Number of Investigations done in last two years in the department** | | | |  |
| **Modality** | | | |  |
| Conventional Radiology |  |  |  |  |
| Contrast Radiology |  |  |  |  |
|  |  |  |  |  |  |  |
| Mammography |  |  |  |  |
| Ultrasound |  |  |  |  |
| Color Doppler |  |  |  |  |
| CT |  |  |  |  |
| MRI |  |  |  |  |
| **Any other Diagnosis / Procedures that are not listed above** | | |  |  |
|  | |  |  |  |  | | --- | --- | --- | --- | | **Case Mix/Spectrum of Diagnosis of PRIMARY HOSPITAL ONLY** | | | | | | Case Mix / Spectrum of Clinical/Surgical Diagnosis | Year Wise No. of Clinical Cases/ Surgical Procedures | | | | 2022 | 2021 | 2020 | | Orthopaedics |  |  |  | | Obstetrics |  |  |  | | Gynaecology |  |  |  | | Pediatrics |  |  |  | | General Medicine |  |  |  | | General Surgery |  |  |  | | Respiratory Disease/ Pulmonology |  |  |  | | Neurology |  |  |  | | Neuro Surgery |  |  |  | | Urology |  |  |  | | Cardiology |  |  |  | | Nephrology |  |  |  | | Gastroenterology |  |  |  | | Oncology |  |  |  | | Others |  |  |  | | **Number of Investigations done in last two years in the department** | | | | | **Modality** | | | | | Conventional Radiology |  |  |  | | Contrast Radiology |  |  |  | |  |  |  |  | | Mammography |  |  |  | | Ultrasound |  |  |  | | Color Doppler |  |  |  | | CT |  |  |  | | MRI |  |  |  | | **Any other Diagnosis / Procedures that are not listed above** | | |  | | | | | | |
| **3.3.** | **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 - Radio Diagnosis Programme in the Hospital/Institute Library |  |
| **4.2.** | Details of Journals subscribed for DNB - Radio Diagnosis trainees | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 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 - Radio Diagnosis 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 |  | |
| **1st Year** | | | |  | |
| Conventional Radiography,  Dark room procedures, Portable Radiography | 1st - 3rd month |  |  |  | |
| Special investigations (Urogenital & Gastroentestinal), Assisted interpretation | 4-9th month |  |  |  | |
| USG & CT-Basics | 10-12th month |  |  |  | |
| **2nd Year** | | | |  | |
| MRI | 2 months |  |  |  | |
| Conventional + Mammography | 2 months |  |  |  | |
|  |  |  |  |  |  |  | |
| Barium procedures | 1 month |  |  |  | |
| Urogenital procedures | 1 month |  |  |  | |
| USG | 3 months |  |  |  | |
| CT Supervised reporting | 3 months |  |  |  | |
| **3rd Year** | | | |  | |
| Angiography, CRCP, Cardiac Procedure observation | 1 month |  |  |  | |
| Conventional + Mammography | 2 months |  |  |  | |
| Barium & urological procedure | 2 months |  |  |  | |
| USG, CT & MRI | 2 months each |  |  |  | |
| Elective | 1 month |  |  |  | |
|  | | | | | | |
|  | Certified copy of MoU with other NBEMS accredited institute / hospital or medical college where DNB - Radio Diagnosis 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 - Radio Diagnosis 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 - Radio Diagnosis Trainees have been registered in the department? |  |
| b. | How many DNB - Radio Diagnosis Trainees have completed their training? |  |
| c. | How many DNB - Radio Diagnosis 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |