**UNDERTAKING & DECLARATION**

*To be completed on an official letter head/stationary of Directorate of Health Services of Respective State Government*

**UNDERTAKING FOR DNB PROGRAMME AT DISTRICT HOSPITALS IN THE STATE OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Name of the applicant District/Civil/General Hospital)**

The State Govt. of \_\_\_\_\_\_\_\_\_\_\_\_ has applied for accreditation of following district hospital in the State for DNB programme as under:

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| --- | --- | --- |
| **Applicant District Hospitals** | **Annexed Secondary Node with the applicant District Hospital for DNB training** | **Specialty applied for** |
|  |  |  |

It is hereby undertaken that:

1. The State Govt will ensure that an operational tie up with annexed secondary node, the facilities/infrastructure of which are proposed to be utilized for training of DNB trainees at applicant district hospital, will continue uninterrupted for the period of accreditation.
2. No changes in the faculty will be made within the period of accreditation. However, under extreme circumstances if the Faculty/Guide present at the time of assessment at any of the applicant district hospital and its partner secondary node is to be replaced, the same be carried out within 2 months under intimation to the NBE and the total no. of faculty will not be reduced under any circumstances.
3. The selection procedure for the DNB candidates at above mentioned hospital shall be made only through the Centralized Merit Based Counseling conducted by the National Board of Examinations for admission to DNB courses in every admission session as per time schedule & guidelines notified by NBE. **There is no other admission methodology for DNB courses**.
4. The State Govt will facilitate participation of faculty from the applicant district hospitals/annexed secondary node in periodic faculty development/training of trainer’s workshop.
5. The State Govt. will ensure that DNB training at applicant district hospitals will be carried out in accordance with prescribed NBE guidelines only.

Date:

Place: **Principal** **Secretary**

Directorate of Health Services, MoHFW

Govt. of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_