HBOT Academy

APPLICATION FOR CONTINUATION/ RENEWAL OF AFFILIATION FOR FELLOWSHIP/CERTIFICATE COURSE FOR THE A.Y. 2023-24

INSTRUCTIONS

1. The Management/Institute/College/Training Centre/Hospital/University Department seeking

   (i) Continuation/Renewal of Fellowship/Certificate Course(s), shall submit the application(s) in given format (No need to attached any hospital documents as these documents shall be uploaded/available on your Training Centre website.)

   (ii) Proposal shall be in single copy with soft copies in a Pen drive, (soft copy shall be PDF Format only).

   (iii) Consolidated payment by online payment Gateway (Click on link to pay Online https://muhs.unisuite.in/)

   (a) **Rs 50,000/-** per course for Continuation/Renewal of Fellowship Course &

   (b) **Rs 40,000/-** per course for Continuation/Renewal of Certificate Course

2. '**Continuation/Renewal of Affiliation**' for Fellowship and Certificate Course(s) for **every Academic Year is mandatory**.

3. Read the 'Rules and Regulations' carefully before filling the application.

4. Strike-out whichever not required/ OR Where ever the fields are not applicable, please Mention as **–N. A. –**

Address – HBOT Academy Sailee Hospital, Prathamesh Horizon, Mew MHB colony, New Link Road, Borivali West, Mumbai – 400091.
Phone: +91 9320065511 | Email – info@hbot.in | Website – www.hbot.in

MAHARASHTRA UNIVERSITY OF HEALTH SCIENCES, NASHIK
दिंडोरी रोड म्हसरुळ, नाशिक - ४२२००४ Dindori Road, Mhasrul, Nashik - 422004
Tel: (0253) 2539156/197, Student Helpline: (0253) 2539111/6659111
Website: www.muhs.ac.in, E-mail: fccc@muhs.ac.in

स्वातंत्र्याचा अमृत महोत्सव

Application for Continuation of Affiliation forFellowship/Certificate Course(s)

(As per provisions of the Maharashtra University of Health Sciences Act, 1998 and University Rule / Guidelines)

To,

The Registrar,
Maharashtra University of Health Sciences,
Vani – Dindori Road, Mhasrul,
Nashik 422 004

Sir,

I am/We are herewith submitting the application with a request under section ~~64 (3)~~ of the Maharashtra University of Health Sciences Act, 1998, for Continuation of my/our Institute for renewal of Fellowship/Certificate Course in, **HYPERBARIC MEDICINE AND BASIC WOUND MANAGEMENT** with an Intake Capacity of **10** students, from the academic year 2023 - 24

Following are the particulars:

- **Purpose of Present inspection:** (Tick whichever applicable and strike-out whichever not applicable)

  (Renewal of Affiliation/Continuation/Compliance Verification)

- **Date of last inspection of the department:** **28th June 2022**

  (Write Not Applicable for first inspection)

- **Purpose of Last Inspection:** **Continuation**

- **Result of last Inspection:** **Permitted**
  (Copy of University Letter to be attached)

- **Fellowship/Certificate Course Co-ordinator Details:**

  Name: **Dr Manoj Gupta**

  Mobile/Telephone no.: **9322237369**

  e-mail id: **drmdg1973@gmail.com,**

PART – I
(INSTITUTIONAL INFORMATION)

1. **Particulars of Director / Dean / Principal:** *(Who so ever is Head of Training Centre)*
Name: Dr. manoj Gupta Age: 49yrs *(Date of Birth)* 04/04/1973

PG Degree	Subject	Year	Institution	University
Recognized / Not Recognized	MD	1999	TNMC	MUMBAI

B.Sc (HYPERBARIC MEDICINE) 2016 STELLENBOSCH UNIVERSITY

Teaching Experience

Designation	Institution	From	To	Total Exp.
Asst. Professor				
Asso. Professor/Reader				
Professor				
Any Other		Grand Total		

2. **Management/Society/Inst. Information :**

01	i) **Name of the Society/Institution/ College/University Department:**	SAILEE HOSPITAL HBOT ACADEMY
	ii) Postal Address, with PIN:	BORIVALI WEST. MUMBAI 400091
	iii) Contact Details:	Mob: 9322237369 Tele: 022-28605544
	iv) E-mail ID:	
02	**Society/Institution/College Registration Number and date:**	i) Public Trust Act 1950: ..... NA .....
		ii)Society's Registration Act.1860:..... NA .....
		iii) Year of establishment:
		iv) Copies of Registration, Constitution and Memorandum of Association attached? *Yes/No ✓ *(Required to upload said documents on Training Centre website)*
03	**Hospital Information :** ***(It is mandatory for Training Centre/applying Institute to have their own functional Hospital as per norms)*** i) Name of the Hospital ii) Nursing Home Registration No. iii) Establishment Year	SAILEE HOSPITAL ..... ATTACHED ..... 2005 ..... *(Required to upload said documents on Training Centre website)*
04	**i) Name of the College/Institute where course is to be conducted:**	SAILEE HOSPITAL HBOT ACADEMY
	ii) Postal Address, with PIN: iii) Contact Details: iv) E-mail ID:	BORIVALI WEST, MUMBAI 400091 Mob: 9322237369 Tele: 022-28605544
	v) List of University approved Fellowship/Certificate Course(s) **conducted / already running** at Training Centre with Intake Capacity	**Name of the Course(s) ..... Approved Intake Capacity... ... ... Affiliated Since... ... (if necessary Attach separate List)** ATTACHED
	vi) Training Centre / Institute **willing/desirous to Start/Open** Fellowship/Certificate Course(s) (For New Opening Purpose only)	**Name of the Course(s) ..... Required Intake Capacity... ... ... (if necessary Attach separate List)** NA
05	Fee details : Click on link to pay Online https://muhs.unisuite.in/	Valid Online Receipt Attached? *Yes/No. ✓
06	Financial position of the Society/ Institute in the preceding 03 years:	Audited Statements of Accounts for *Yes/No *(Required to upload said documents on Training Centre website)*
07	Budgetary provision for the FC/CC/DC for the next 03 years:	i) 2022 - 23 Rs ...15. LAKHS
08	Management Resolution seeking Recognition of Institute for FC/CC of MUHS, Nashik:	Resolution No. ..... dated ..... Copy of Management Resolution attached? *Yes/No

09	**Other Information:**	
	a) Land:	*Yes/No. If yes, then Area: 6500 Sq. Ft
	i) Whether the land is owned by the Applicant Institute/College/ Trust:	Copy of land documents i.e. 7/12 extract, Property Card, etc. attached? *Yes/No ***(Required to upload said documents on Training Centre website)***
	ii) Whether the land is registered?	*Yes/No. If yes, Registration Number: ..... dated .... at (Place): ....NA..... Copy of Land Registration Certificate attached? *Yes/No ***(Required to upload said documents on Training Centre website)***
	iii) Any loans, mortgage, etc. shown against the title of the land:	*Yes/No. If yes, amount of loan Rs..... /mortgaged for Rs ..... NO Copy of Loan/Mortgage Deed attached? *Yes/No. ***(Required to upload said documents on Training Centre website)***
	b) Building: i) Total built-up area:	Area in. ..... sq. ft. Certified copy of Building Plan attached? *Yes/No ATTACHED ***(Required to upload said documents on Training Centre website)***

3. Central Library

- Total number of Books in library: 100
- ☐ Books pertaining to concerned Fellowship subject: 20
- ☐ Purchase of latest editions of concerned books in last 3 years: - 7

- Journals:

Journals	Total	concerned Fellowship subject
Indian	2	YES
Foreign	2	YES

- Year / Month up to which latest Indian Journals available: YES
- Year / Month up to which latest Foreign Journals available: JAN 2022
- Internet / Med pub / Photocopy facility: available / not available
- Library opening times: 8AM TO 8PM
- Reading facility out of routine library hours: available / not available

(Obtain list of books & journals duly signed by Dean)

4. Recreational facilities: **Available / Not available**

Play grounds Gymnasium

5. Hostel Accommodation:

Particular	UG		PG		Interns	
	Boys	Girls	Boys	Girls	Boys	Girls
No. of Rooms						
No. of Students		NA				
Status of Cleanliness						

6. Residential accommodation for Staff / Paramedical staff: Available /Not Available

7. Ethical Committee (Constitution): YES/NO

8. Medical Education Unit (Constitution): YES/NO *(Specify number of meetings held annually & minutes thereof)*

9. Any other faculty specific information required :(such as Herbal garden / Panchakarma Unit /Pharmacy / Dental Chairs and Units/as per the requirement) NO

PART – II

(HOSPITAL INFORMATION)

1. **Name of the Hospital:** Sailee Hospital

2. **Total number of OPD, IPD in the Institution and concerned department during the last one year:**

In the entire hospital		In the department of concerned Fellowship subject	
OPD	5000	OPD	200 / month
IPD (Total No. of Patients admitted)	Average 100 / month	IPD (Total No. of Patients admitted)	—

3. **Hospital Beds Distribution & No of O.T.:**

In the entire hospital	
No of Beds	20
No of Beds in ICU	6
No of Beds in IRCU	—
No of Beds in SICU	—
No of Major O.T.	1
No of Minor O.T.	1

4. **Available Clinical Material: (Give the data only for the department of concerned Fellowship subject)**

- No. of available for clinical service on inspection day:

	On Inspection day	Average of random 3 days
☐ Daily OPD – 2 PM	.....	.....
☐ Daily admissions	.....	.....
• Daily admissions in Dept. Through casualty at 10am	.....	.....
• Bed occupancy in the Dept. at 10AM	.....	.....
• Number of patients in ward (IPD)	.....	.....
• Percentage bed occupancy at 10Am	.....	.....

- Clinical Procedure(s)& Operative Details related to Fellowship subject/Specialty :***(For further details in this concern, kindly peruse the Guidelines information sheet supplied herewith)***

	On Inspection day	Average of random 3 days
•	.....	
☐	.....	.....
☐	.....	.....
☐	.....	.....
☐	.....	.....

5. Casualty:/ Emergency Department:

Space	6500 sq. ft.
Number of Beds	20
No. of cases (Average daily OPD and Admissions):	30
Emergency Lab in Casualty (round the clock):	Available / Not Available
Emergency OT and Dressing Room	Yes
Staff (Medical/Paramedical)	Yes
Equipment available	Yes

6. Blood Bank:

(i)	Valid FDA License(copy of certificate be annexed)	Yes / No	
(ii)	Blood component facility available	Yes / No	
(iii)	All Blood Units tested for Hepatitis C,B, HIV	Yes / No	
(iv)	Nature of Blood Storage facilities (as per specifications)	Yes / No	
(v)	Number of Blood Units available on inspection day		
(vi)	Average blood units consumed daily and on inspection day in the entire Hospital (give distribution in various specialties)	Average daily	On Inspection day

Obt Saved

7. Central Laboratory:

- Controlling Department: Yes
- No of Staff: 3
- Equipment Available: Attach separate List Yes
- Working Hours: _____

8. Central supply of Oxygen / Suction: Available / Not available

9. Central Sterilization Department Available / Not available

10. Ambulance (Functional) Available / Not available

11. Laundry: Manual/Mechanical/Outsourced:

12. Kitchen Available / Outsourced/ Not Available

13. Incinerator: Functional / Non functional Capacity: ..... /Outsourced

14. Bio-Medical waste disposal Outsourced / any other method

15. Generator facility Available / Not available

16. Medical Record Section: Computerized / Non computerized

☐ ICD X classification Used / Not used

Sign & Stamp
Head of the Department
Date:

HBOT ACADEMY

Sign & Stamp
Dean/Principal/Head of Institute
Date:

HBOT ACADEMY

College / Institute Round Seal

PART – III

(To be filled by the Local Inquiry Committee)

(DEPARTMENTAL INFORMATION)

1. **Fellowship Specialty Department to be inspected** :.....
2. **Date on which independent department of functioning concerned specialty was created and started** : .....
3. **Faculty details (From start of department till date):**

Sr. No.	Name	Full Time/ Part Time	Designation	Qualification	Experience in Yrs. (after acquiring PG Qualification in concerned Subject)

4. **Whether Independent Department of concerned Fellowship/Certificate subject exists in the Institution:** Yes/No: ..... Since when: .....
5. **Specialty Department Infrastructure Details:**

Facility	Area (sft.)	Available	Not Available
Faculty rooms			
Clinics			
Laboratory Space			
Seminar room			
Department Library			
PG common room			
Preclinical lab (where ever applicable)			
Patient waiting room			
Total area			

6. **Year-wise number of students admitted to Fellowship/ Certificate course during last 5 years:**

Sr. No.	Name of Fellowship/ Certificate Course	Academic Year	Intake Capacity	No. of Students Admitted (In figure only)
1	Please write name of course	A.Y. 2017 - 2018		
		A.Y. 2018 - 2019		
		A.Y. 2019 - 2020		
		A.Y. 2020 - 2021		
		A.Y. 2021 - 2022		

(Local Inquiry Committee shall specifically ensure about availability of eligible/validated Mentor(s) and shall check whether the Training Center met with the Student: Mentor Ratio for the permitted Intake Capacity for each course or else it shall be reported in the Overall Remark Option.)

7. **List of Non-Teaching Staff in the department:**

Sr. No.	Name	Designation

Equipment's: List of Important equipment's available and their functional status
(List here only- No annexure to be attached)

Sr. No.	Name of the Equipment	Specification	Functional / Not Functional	Qty.

9. Intensive care Service provided by the Department: (Emergency)

10. Specialty clinics being run by the department and number of patients in each :

Sr. No.	Name of the clinic	Days on which held	Timings	Average No. of cases attended	Name of Clinic In-charge

11. Services provided by the Department:

a) Services

i. _____

ii. _____

iii. _____

(b) Ancillary Services

(c) Others: _____

12. Space:

Sr. No	Details	In OPD	In IPD
1	Patient Examination/ Checking Arrangement		
2	Equipment's		
3	Teaching Space		
4	Waiting area for patients		

13. Office space:

Department Office		Office Space for Teaching Faculty	
Space (Adequate)	Yes/No	HOD	
Staff (Steno /Clerk).	Yes/No	Professors	
Computer/ Typewriter	Yes/No	Associate Professors	
Storage space for files	Yes/No	Assistant Profess or	
		Residents	

14. Clinical Load of Dept. : No of Surgeries / Procedures ..... Per day

15. Submission of data to National Authorities if any: _____

_____

_____

16. **Overall Impression:** ***(To be filled by the Local Inquiry Committee)***

Particular	Deficient	Satisfactory
Infrastructure		
Clinical Material		
Staff Assessment		
Student Assessment		
Library facilities		
Equipment		
Overall Department Assessment		

17. **Any Other Observations & Overall Remarks of The Local Inquiry Committee** (Not More Than 3 Lines): ***(To be filled by the Local Inquiry Committee)***

Sr. No.	Particular	-	
01.	Recommendation for Recognition of the Institute (If applicable)	:	
02.	Recommendation for Starting New Fellowship / Certificate Courses (If applicable)	:	
03.	Recommendation for Existing Fellowship/ Certificate Courses For Continuation of Recognition/ Affiliation (If applicable)	:	
04.	Recommendation for Increase in Intake of Fellowship / Certificate Courses (If applicable)	:	

	Name of the LIC Chairman/Members	Signature
01		
02		
03		

ANNEXURE – "I"

Information of Mentor of Training Centre

It shall be verified by the Head of the concerned Training Center,

Sr. No.	Particular		Information to be filled
01.	Name of the Mentor	:	Dr. Manoj Gupta
02.	Date of Birth	:	04/04/1973
03.	Address	:	Borivali West
04.	Tel. No./ Mob. No.	:	9322237369
05.	e-mail id	:	drmdg1973@gmail.com
06.	Nationality	:	Indian
07.	Qualification in details : (attach documentary proof)	:	Attached
08.	Teaching Experience / Health Sciences: Profession Experience (Attached document proof with signature of Head of the Institute. Also it is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in the Subject of concerned Fellowship/Certificate Course)	:	Attached
09.	Present Appointment	:	Director / Mentor
10.	Publications (List & Proof)	:	Attached
11.	Post Graduate Teaching experience (Attach documentary evidence)	:	5 years
12.	Any other relevant information	:	

Date: -

Name & Sign. of Mentor

For the use of affiliated Training Center:

I have verified the eligibility of the above Mentor as per the criteria of eligibility prescribed by the University vide clause no.7 of the University Direction No. 05/2017 (Amended) and University Circular No. MUHS/UDC/FCCC/736/2019 dated 30/09/2019.

Sign & Stamp
Head of the Department
Date:

Sign & Stamp
Dean/ Principal/ Director of Training Centre
Date:

Training Centre Round Seal

Annexure - II

Professional/Teaching Experience Certificate for Fellowship/Certificate Courses Faculty/Teachers/Consultant/Mentor

Title of the Course applied for: -

This is to Certify that Dr. Dr. Manoj Gupta has worked in the Department of Hyperbaric Medicine College / Institutes as per following details.

A) General Experience: -

Designation	From	To	Total period Year / Month	
Mentor	2017-18	till date	5 years	

B) Actual Experience in the Subject of concerned Fellowship/Certificate Course applied for :-

Designation	From	To	Total period Year / Month	
Mentor	2017-18	till date	5 years	

(It is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in the Subject of concerned Fellowship/Certificate Course)

Sign& Stamp Head of the Department

Date:

HBOT ACADEMY

Sign & Stamp Dean/Principal/Head of Institute

Date:

HBOT ACADEMY

Recommended/Not Recommended

Signature with date of LIC Chairman/Member

(This is original copy for payee.) 2022 - 2023

S5047

Academic Year : 2022 - 2023

MUHS

Maharashtra University of Health Sciences

Original Copy

Receipt No : 1522100/2223 **Date** : Monday, 3 October, 2022

Under Section : [5047] University Department Cell (Fellowship)

Received From : HBOT Academy sailee Hospital, New Mumbai, Pin-400091

Narration : CRF-Continuation/Renewal Fee For Fellowship Course (For 1 Course) ((101161))

Email Address : drmdg1973@gmail.com **Mobile No.** : 9322237369

On Account Of	Amount [Rs]
1. 4161 ER10501 Fellowship /Certificate Program Continuation Of Affiliation Fees	50,000.00
2. 4162 ER10502 Fellowship/ Certificate Program Application Fees	0.00
3. 4163 ER10503 Fellowship/certificate Program Syllabus Fees	0.00
Subject To Relisation Receipt Total	**50,000.00**

Rupees (in words) : Fifty Thousand Rupees Only.

Payment Details : 1 Net Bank

1. 03.10.22 50,000.00 By Net Bank 15985468331, ORC for Token FSTKN0002974875298

College : 101161 -HBOT Academy Sailee Hospital, New Mumbai, Pin-400091

Receipt Type: StudentFees

Receiver : Online Receipt Counter Registrar MUHS, Nashik

Monday, 3 October, 2022 06:32 pm [AD: 1111, ORC, ORC, -1] Page 1 of 1

(This copy is to submit to respective section for which payee paid/paying this.) 2022 - 2023

S5047

Academic Year : 20

MUHS

Maharashtra University of Health Sciences

University Copy

Receipt No : 1522100/2223 **Date** : Monday, 3 Oct

Under Section : [5047] University Department Cell (Fellowship)

Received From : HBOT Academy sailee Hospital, New Mumbai, Pin-400091

Narration : CRF-Continuation/Renewal Fee For Fellowship Course (For 1 Course) ((101161))

Email Address : drmdg1973@gmail.com **Mobile No.** : 93

On Account Of	Amo
1. 4161 ER10501 Fellowship /Certificate Program Continuation Of Affiliation Fees	
2. 4162 ER10502 Fellowship/ Certificate Program Application Fees	
3. 4163 ER10503 Fellowship/certificate Program Syllabus Fees	
Subject To Relisation Receipt Total	

Rupees (in words) : Fifty Thousand Rupees Only.

Payment Details : 1 Net Bank

1. 03.10.22 50,000.00 By Net Bank 15985468331, ORC for Token FSTKN0002974875298

College : 101161 -HBOT Academy Sailee Hospital, New Mumbai, Pin-400091

Receipt Type: StudentFees

Receiver : Online Receipt Counter Registrar MUHS, Nashik

Monday, 3 October, 2022 06:32 pm [AD: 1111, ORC, ORC, -1] P