APPLICATION (NEW & FOR CONT. OF AFFILIATION) CUM VISITATION PERFORMA APPLICABLE FOR FELLOWSHIP/CERTIFICATE COURSE(S) – ANNEXURE - C

Training Center Letter Head

INSTRUCTIONS:

(i) Application for Recognition of Institute for Starting Fellowship/Certificate Course(s)
(ii) Application to Start/Increase Intake Capacity of Fellowship/ Certificate Course(s)
(iii) Application for Continuation/Renewal of Fellowship/Certificate Course(s)

1. The Management/Institute/College/Training Centre/Hospital/University Department seeking
   - (i) Recognition of MUHS for starting Fellowship/Certificate Course(s),
   - (ii) Permission to Start/Increase Intake Capacity of Fellowship/Certificate Course(s) and
   - (iii) Continuation/Renewal of Fellowship/Certificate Course(s), shall submit the application(s) in box type of File.
     - (a) **in original, along-with the attested supporting documents mentioned therein,** and
     - (b) **soft copies in a Pen drive, in .PDF FORMAT ONLY**, containing scanned copies of
       - (aa) **Original** application(s) for Recognition of Institute/Start/Increase Intake Capacity/ Continuation/Renewal of Fellowship/Certificate Course(s) and,
       - (bb) **All the mandatory supporting documents** as mentioned in the respective applications,
   - (iii) Consolidated single NEFT/Demand Draft of
     - (a) **Rs 2,00,000/-** towards 'Fees for Recognition of Training Center',
     - (b) **Rs 50,000/-** per course for Starting/Continuation/Renewal of Fellowship Course
     - (c) **Rs 40,000/-** per course for Starting/Continuation/Renewal of Certificate Course drawn in favour of 'The Registrar, Maharashtra University of Health Sciences, Nashik' on any Nationalized Bank, payable at Nashik.

2. Fee for Recognition of Institute and Starting of New / Continuation/Renewal of / Fellowship or Certificate Course shall be as per Affiliation Fee Notification as amended by the University from time to time.

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

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

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

महाराष्ट्र आरोग्य विज्ञान विद्यापीठ, नाशिक
Maharashtra University of Health Sciences, Nashik
दिंडोरी रोड, म्हसरुळ, नाशिक ४२२००४ Dindori Road, Mhasrul, Nashik 422004
Tel : (0253) 2539244/241/156, Fax : (0253) 2539242
www.muhs.ac.in, fccc@muhs.ac.in

Local Inquiry Committee Inspection format for Continuation of Affiliation/Recognition For affiliated /or Training Center's conducting Fellowship/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 Local Inquiry Committee Inspection format for Continuation of Affiliation/Recognition For affiliated Training Center's conducting Fellowship/Certificate Course(s)

Sr. No.	Name of the Fellowship/Certificate Course	Course Started from the Academic Year	Intake Capacity Sanctioned by the University	No. of Student(s) Admitted (on the day of Inspection)
01	Hyperbaric	2018-19	10	0
02	medicine and			
03	Basic wound			
..	Management			
..				

(Attach separate List if necessary)

- **Purpose of Present inspection:** (Tick whichever applicable and strike-out whichever not applicable) ✓
  Grant of Permission/ Recognition/ Increase of seats/Renewal of Affiliation/recognition/Compliance Verification

- **Date of last inspection of the department:** october 2019
  (Write Not Applicable for first inspection)

- **Purpose of Last Inspection:** continuation

- **Result of last Inspection:** Allowed to continued.
  (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 Tanuj Gupta Age: 47 *(Date of Birth)* 04/04/1973

PG Degree *Recognized / Not Recognized*	Subject	Year	Institution	University
	FMT	1999	TNMC	Mumbai
	B.Sc HBO	2012	USA	USA.

Teaching Experience

Designation	Institution	From	To	Total Exp.
Asst. Professor	Attached.			
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-400092
	iii) Contact Details:	Mob: 9322237369. Tele: 28005404
	iv) E-mail ID:	
02	**Society/Institution/College Registration Number and date:**	i) Public Trust Act 1950: . . . . ii)Society's Registration Act.1860:. . . . . iii) Year of establishment: 2100 . iv) Copies of Registration, Constitution and Memorandum of Association attached? *Yes/No– Mark as Appendix 'A'
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 – Mark as Appendix 'B'
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(w) Mumbai-91 Mob: 9322237369 Tele: drmdg1973@gmail.com
	v) List of University approved Fellowship/Certificate Course(s) **conducted / already running** at Training Centre with Intake Capacity	**Name of the Course(s)** .... Hyperbaric Medicine and Basic wound Management **Approved Intake Capacity**..10. ... **Affiliated Since**... ... 2018 **(if necessary Attach separate List)**
	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)**
05	Affiliation Fees details: (Bank/DD no./ date/amount/ NEFT/RTGS)	Paid Fees details Attached : *Yes/~~No~~. (Pending Fees, if any;)
06	Financial position of the Society/ Institute in the preceding 03 years:	Audited Statements of Accounts for *Yes/No– Mark as Appendix 'C' NA
07	Budgetary provision for the FC/CC/DC for the next 03 years	i) 2020... Rs ..10. Lacs
08	Management Resolution seeking Recognition of Institute for FC/CC/DC of MUHS, Nashik:	Resolution No. . . . . dated . . . . Copy of Management Resolution attached? *Yes/No– – Mark as Appendix 'D' NA

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– Mark as Appendix 'E' own
	ii) Whether the land is registered?	*Yes/No. If yes, Registration Number: .... dated .... at (Place): ...........N.A..... Copy of Land Registration Certificate attached? *Yes/No.– Mark as Appendix 'F'
	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. – Mark as Appendix 'G'
	b) Building: i) Total built-up area:	.... sq. ft. Certified copy of Building Plan attached? *Yes/No Attached. – Mark as Appendix 'H'

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		5	Hyperbaric med
	Foreign		1	Hyperbaric med.

- Year / Month up to which latest Indian Journals available: Sept 2019
- Year / Month up to which latest Foreign Journals available: ______
- Internet / Med pub / Photocopy facility: available / not available
- Library opening times: 8am – 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 NA

5. **Hostel Accommodation:**

Particular	UG		PG		Interns	
	Boys	Girls	Boys	Girls	Boys	Girls
No. of Rooms						
No. of Students		NA		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 of concerned Course) Attach details NA

PART – II

(HOSPITAL INFORMATION)

1. Name of the Hospital: Sailee Hospital and Diagnostic centre.

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	50 (morning)	OPD	8
IPD (Total No. of Patients admitted)		IPD (Total No. of Patients admitted)	

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

In the entire hospital	
No of Beds	25
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	…………………	30-40 Patients.
Daily admissions	Avg 2-3 pt	8-10
Daily admissions in Dept. Through casualty at 10am	2	2-3
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	Aver age of random 3 days
• …………………	…………………	
•	…………………	…………………
•	…………………	…………………
•	…………………	…………………
•	…………………	…………………

5. Casualty:/ Emergency Department :

Space	200 Sqft
Number of Beds	2
No. of cases (Average daily OPD and Admissions):	(30-50) (2-3)
Emergency Lab in Casualty (round the clock):	✓ available / not available
Emergency OT and Dressing Room	Available
Staff (Medical/Paramedical)	Available
Equipment available	Available

6. Blood Bank : NA Outsourced.

(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

7. Central Laboratory:

- Controlling Department: Pathology inhouse.
- No of Staff : 4
- Equipment Available : Attach separate List yes
- Working Hours: 24 hrs.

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: (✓ Manual, ✓ Mechanical)

12. Kitchen Available/~~Outsourced~~/~~Not Available~~ (✓ 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:

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

College/Institute
Round Seal

DR. MANOJ GUPTA
MBBS,MD,DNB,LLB
Reg - 79197
CAQ (Hyperbaric Medicine) UHMS(USA)
BSC (HYPERBARIC Medicine) South Africa
Level 1 (Medical Examiner of Divers)
As approved bt DMAC/ EDTCmed
HYBERBARIC PHYSICIAN

DR. MANOJ GUPTA
MBBS,MD,DNB,LLB
Reg - 79197
CAQ (Hyperbaric Medicine) UHMS(USA)
BSC (HYPERBARIC Medicine) South Africa
Level 1 (Medical Examiner of Divers)
As approved bt DMAC/ EDTCmed
HYBERBARIC PHYSICIAN

PART – III

(To be filled by the Local Inquiry Committee)

(DEPARTMENTAL INFORMATION)

(If required Use Separate Sheet for each Department / Fellowship/Certificate Course)

1. **Fellowship Specialty Department to be inspected** :.....Hyperbaric medicine.....
2. **Date on which independent department of functioning concerned specialty was created and started** ....2010..................

3. **Mentor's 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)
1)	Dr. Anand Gupta	Full time	Director	MD BSc (Hyperbaric med)	20 (10 in HBOT)

4. **Whether Independent Department of concerned Fellowship subject exists in the Institution :**
   Yes/~~No~~: ....Yes....... Since when: ...2010.....

5. **Specialty Department Infrastructure Details :**

Facility	Area (sft.)	Available	Not Available
Faculty rooms	150 sq ft	✓	
Clinics	100 sq ft	✓	
Laboratory Space			
Seminar room	Hospital	200 sqft	✓
Department Library	200 sq ft		
PG common room			
Pre clinical lab (where ever applicable)			
Patient waiting room	100 sq ft.		
Total area	350 sq ft.		

6. **If course already started, year wise number of students admitted and available Mentors to teach students admitted to Fellowship / Certificate Course during the last 3years:**

Year	Name of the Course	No. of students admitted	No. of Valid Mentors available in the dept. (give names)
1)	Hyperbaric medicine	0	1

(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
	Attached.	

8. **List of Equipment(s) in the department of concerned Fellowship subject:**
   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.
1)	Monoplace chamber		Functional	1
2)	multiplace chamber		Functional	1

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
1)	medical	daily	10am - 1pm, 7pm - 10pm	35-40	Dr Chetan Patil
2)	surgical/ortho	daily	7pm - 9pm	8-10	Dr Ravi Ghugare / Dr Kunal C

11. **Services provided by the Department:**

a) Services

i. orthopaedics

ii. Gynecology

iii. ENT

iv) Paediatrics

v) plastic surgery

(b) Ancillary Services Labratory / Radiology

(f) Others: -

12. **Space:**

Sr. No	Details	In OPD	In IPD
1	Patient Examination/ Checking Arrangement	100 sq ft x 3	Beds
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** 2-3 **Per day**

15. **Submission of data to National Authorities if any :** MCGM.

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 theLocal 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 to be filled by the each Mentor,
It shall be verified by the Head of the concerned Training Center,
Subsequently endorsed by Local Inspection Committee at the time of visitation.

Sr. No.	Particular	-	Information to be filled
01.	Name of the Mentor	:	Dr Manoj Gupta
02.	Date of Birth	:	4/4/1973
03.	Address	:	Borivali(W), M-400091
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 /Consultant/Mentor (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)	:	see sub-tables A and B below
09.	Present Appointment	:	Head of Dept.
10.	Publications (Lis t & Proof)	:	attached.
11.	Post Graduate Teaching experience (Attach documentary evidence) 6 yrs	:	
12.	Any other relevant information	:	

A) General Experience:

Designation	From	To	Total Period (Yrs. & Months)
Attached.			

B) Experience in the Subject of concerned Fellowship/Certificate Course:

Designation	From	To	Total Period (Yrs. & Months)
Head	2010	date	11 years

Date :- **Name & Sign. of Mentor**

For the use of affiliated Training Center:

On the basis of experience certificates and documents submitted by the concerned Mentor, 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).

Sign of Head of the Department
(HOD of concerned Department of Fellowship Subject, if any ;)
Date:

DR. MANOJ GUPTA
MBBS,MD,DNB,LLB
Reg - 79197
CAQ (Hyperbaric Medicine) UHMS(USA)
BSC (HYPERBARIC Medicine) South Africa
Level 1 (Medical Examiner of Divers)
As approved bt DMAC/ EDTCmed
HYBERBARIC PHYSICIAN

Sign & Stamp of Head of the Training Center
(Director / Dean/Principal of the Training Center/ Institute/Hospital/College/Health Center)
Date:

DR. MANOJ GUPTA
MBBS,MD,DNB,LLB
Reg - 79197
CAQ (Hyperbaric Medicine) UHMS(USA)
BSC (HYPERBARIC Medicine) South Africa
Level 1 (Medical Examiner of Divers)
As approved bt DMAC/ EDTCmed
HYBERBARIC PHYSICIAN

For the use of LIC Chairman/Member:

Above candidate is Recommended /Not Recommended for Mentor
(Tick whichever applicable and strike-out whichever not applicable)

Name & signature with date of LIC Chairman/Member

Chairman: ....
Date :

Member : ....
Date :