**STANDARD ASSESSMENT FORM FOR PG COURSESYEAR 2020-21**

**(Report in this SAF prescribed for the year 2020-21 will only be accepted)**

 **SUBJECT - Neonatology**

***INSTRUCTIONS TO DEANS & ASSESSORS***

1. Please read the SAF carefully before filling it up. Retrospective changes in Data will not be allowed.
2. **Do not use Annexures. All information should be provided in SAF at appropriate place earmarked. No Annexures will be considered.**
3. Experience details should be supported by experience certificate from competent authority (from the place of work) without which it will not be considered.
4. Don’t add, alter or delete any column of SAF.
5. In case of DNB qualification name of the hospital/institution from where DNB training was done and year of passing must be provided. Simply saying National Board of Examination, New Delhi is not enough. Without these details DNB qualification holder will be summarily rejected.
6. Experience of defence service must be supported by certificate from the competent authority of the office of DGAFMS without which it will not be considered.
7. Dean will be responsible for filling all columns and signing at appropriate places.
8. If promotion is after cut-off date (i.e. after 21/07/2013 for Professor & 21/07/2014 for Associate Professor) or benefit of publications is given in promotion before cut-off date, give the list of publications immediately below the name of faculty in this format: Title of Paper, Authors, Citation of Journal, details of Indexing. Photocopies of published articles should also be submitted without which they will not be considered. Give details of **only** original research articles; Case reports, Review articles and Abstracts will not be considered and should not be included.
9. No abbreviations of the name of Medical College in the Faculty List and Declaration Forms are acceptable

**INSTRUCTIONS TO ASSESSORS:** Please ensure that only original research papers published in indexed print journals are included in the list. Remaining entries, if included, should be struck off.

1. Assessor may give any relevant remarks not shown in the assessment report on the page marked “Remarks of Assessor”. No separate confidential letter should be sent.
2. Count only those faculty & Residents who have signed in attendance sheet before 11:00 a.m. and are present for subsequent verification and are found eligible on verification and also those who are on MCI permitted leave and MCI or Court duty. Do not forget to obtain signature of faculty and residents/senior residents in faculty table in appropriate column.

**STANDARD ASSESSMENT FORM FOR POSTGRADUATE COURSES**

**(Neonatology)**

**1. Name of Institution:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MCI Reference­­­­­­­­­­­­­­­­­­­­ No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Particulars of the Assessor:- Assessment Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name ………………………………………….**

**Designation……………………………………**

**Specialty……………………………………….**

**Name & Address of Institute/College ……………..…………………………………..**

**………………………………………………….**

**………………………….……………………….**

**Residential Address (with Pin Code) ……………………………………………...….**

**………………………………………………....**

**Phone .(Off) ……………(Resi.) …………….**

**(Fax)…………………………………………...**

**Mobile No. ……………………………………**

**E-mail: ………………………………………...**

**3. Institutional Information**

**a). Particulars of college**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | **College** | **Chairman/****Health Secretary** | **Director/** **Dean/ Principal** | **Medical Superintendent** |
| **Name** |  |  |  |  |
| **Address**  |  |  |  |  |
| **State** |  |  |  |  |
| **Pin Code** |  |  |  |  |
| **Phone****(Off)****(Res)** **(Fax)** |  |  |  |  |
| **Mobile No.** |  |  |  |  |
| **E.mail:** |  |  |  |  |

**b). Particulars of Affiliated University**

|  |  |  |  |
| --- | --- | --- | --- |
| **Item**  | **University** | **Vice Chancellor** | **Registrar** |
| **Name** |  |  |  |
| **Address**  |  |  |  |
| **State** |  |  |  |
| **Pin Code** |  |  |  |
| **Phone****(Off)****(Res)** **(Fax)** |  |  |  |
| **Mobile No.** |  |  |  |
| **E.mail:** |  |  |  |

**SUMMARY**

**Date of Assessment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Assessor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| 1. **Name of Institution**

*(Private / Government)* | ***Director / Dean / Principal****(Who so ever is Head of Institution)* |
|  | Name |  |
| Age & Date of Birth |  |
| Teaching experience |  |
| PG Degree *(Recognized/Non-R)* |  |
| Subject |  |

|  |  |
| --- | --- |
| 1. **Department inspected**
 | **Head of Department** |
|  | Name |  |
| Age & Date of Birth |  |
| Teaching experience |  |
| PG Degree /subjects*(Recognized/Non-R)* |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. (a). **Number of UG seats**
 | Recognised(Year: ) | Permitted(Year: ) |  | First LOP date when MBBS course was first permitted  |
|  |  |  |  |
|  (b). **Date of last inspection for** | UG | PG | Super specialty |  |
| Purpose: | Purpose: | Purpose: |  |
| Result: | Result: | Result: |  |

4. Total Teachers available in the Department:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Designation** | **Number** | **Name** | **Total Teaching Experience** | **Benefit of Publications in Promotion** |
| Professor |  |  |  |  |
| Addl./Assoc Professor |  |  |  |  |
| Asstt. Professor |  |  |  |  |
| Senior Resident |  |  |  |  |

*Note: Count only those who are physically present.*

**5.**  Number of Units with beds in each unit:

**6.** Clinical workload of the Institution and Department concerned:

|  |  |  |
| --- | --- | --- |
| **S.no.**  | **Parameter** | **Department of Neonatology** |
| On the Day of Assessment | Average of 3 Days Random |
| 1 | OPD attendance **upto 2 p.m.** |  |  |
| 2 | New admissions |  |  |
| 3 | Total Beds occupied at **10 a.m.** |  |  |
| 4 | Total Required Beds |  |  |
| 5 | Bed Occupancy at **10 a.m. (%)** |  |  |
| 6 | Total number of X-Rays done |  |  |
| 7 | Total number of USG done |  |  |
| 8 | Total number of ABG done |  |  |
| 9 | Total number of patients on photo therapy  |  |  |
| 10 | Total CT/MRI |  |  |
| 11. | Total number of neonates on ventilators |  |  |
| 12 | Bio Chemical investigations |  |  |

*Put N.A. whichever is not applicable to the Department.*

**Note:**

* *OPD attendance is to be considered only upto 2 p.m. Bed occupancy is to be considered at 10 a.m. only.*
* *Investigative Data to be verified with Physical Registers in Radiodiagnosis & Central Clinical Laboratory.*
* *Data to be verified with Physical Registers in Blood Bank.*

**7. Investigative Workload of entire hospital and Department Concerned.**

|  |  |  |
| --- | --- | --- |
| **Parameter** | **Entire Hospital** | **Department of Neonatology** |
| On the Day of Assessment | On the Day of Inspection | Average of 3 Random Days |
| **Radio-diagnosis** | MRI |  |  |  |
|  | CT |  |  |  |
|  | USG |  |  |  |
|  | Plain X-rays |  |  |  |
|  | IVP/Barium etc |  |  |  |
|  | Mammography |  |  |  |
|  | DSA |  |  |  |
|  | CT guided FNAC |  |  |  |
|  | USG guided FNAC |  |  |  |
|  | Any other |  |  |  |
| **Pathology** | Histopath |  |  |  |
|  | FNAC |  |  |  |
|  | Hematology |  |  |  |
|  | Others |  |  |  |
| **Bio-Chemistry** |  |  |  |  |
| **Microbiology** |  |  |  |  |
| **Blood Units Consumed**  |  |  |  |

**8. Year-wise available clinical materials (during previous 3 years) for department of Neonatology**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S.No.** | **Parameters**  | **Year 1** | **Year 2** | **Year 3****(Last Year )** |
| 1 | Total number of patients in OPD  |  |  |  |
| 2 | Total number of patients admitted (IPD) |  |  |  |
| 3 | Total number of ABG |  |  |  |
| 4 | Total number of patient on warmers  |  |  |  |
| 5 | Total number of patients on ventilators  |  |  |  |
| 6 | Total number of Neonates on phototherapy  |  |  |  |
| 7 | Total exchange transfusion |  |  |  |
| 8 | Total Neuro-Radiology (CT/MRI) |  |  |  |
| 9 | Total M.R. Angiogram |  |  |  |
| 10 | Total Carotid Doppler |  |  |  |
| 11 | Neuro-pathological investigation (Muscle / Nerve Brain) |  |  |  |
| 12 | Biochemical investigations |  |  |  |

*Note : Put N.A. for those coloumns not applicable to the department*

**9**. Publications from the department during last 3 years:

 *(Give only full articles published in indexed journals. No case reports or review articles be given)*

|  |
| --- |
|   |

|  |  |  |  |
| --- | --- | --- | --- |
| **10** | **Blood Bank** | License valid | Yes / No(enclose copy) |
|  | Blood component facility available | Yes / No(enclose copy) |
| Number of blood units stored on the inspection day |  |
| Average units consumed daily (entire hospital) |  |

**11**. Specialized services provided by the department: Adequate / not adequate

**12**. Specialized Intensive care services provided by the Dept: Adequate / not adequate

**13**. Specialized equipment available in the department: Adequate / Inadequate

**14**. Space (OPD, IPD, Offices, Teaching areas) Adequate / Inadequate

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **15** | **Library** |  | Central | Departmental |
|  |  | Number of Books pertaining to Neonatology  |  |  |
|  |  | Number of Journals |  |  |
|  |  | Latest journals available upto |  |  |

**16**. Casualty Number of Beds\_\_\_\_\_\_\_Available equipment \_\_\_\_Adequate / Inadequate

**17**. Common Facilities

* Central supply of Oxygen / Suction**:** Available / Not available
* Central Sterilization Department Adequate / Not adequate
* Laundry: Manual/Mechanical/Outsourced:
* Kitchen Gas / Fire
* Incinerator:Functional / Non functional Capacity: Outsourced
* Bio-waste disposal Outsourced / any other method
* Generator facility Available / Not available
* Medical Record Section: Computerized / Non computerized
* ICD10 classification Used / Not used

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

|  |  |
| --- | --- |
| In the entire hospital | In the department of Neonatology |
| OPD |  | OPD |  |
| IPD (Total Number of Patients admitted) |  | IPD (Total Number of Patients admitted) |  |
| Deaths |  | Deaths |  |

19. Number of Births in the Hospital during the last one year:

*Note :1) The data be verified by checking the death/birth registration forms sent by thecollege/hospital to the Registrar, Deaths & Births (Photocopy of all such forms be provided.)*

 *2) Year means calendar year (1st January to 31st December )*

20. Accommodation for staff Available / Not available

21. Hostel Accommodation

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S.****No** | **Number** | UG | PG | Interns |
| Boys | Girls | Boys | Girls | Boys | Girls |
| 1 | No. of Students |  |  |  |  |  |  |
| 2 | No. of Rooms |  |  |  |  |  |  |
| 3 | Status of Cleanliness |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **22** | **Total number of PG seats in the concerned subject** |  | Recognized seats | Date of recognition | Permitted seats | Date of permission |
| Degree |  |  |  |  |
| Diploma |  |  |  |  |

**23.** Year wise PG students admitted (in the department inspected) during the last 5 years and available PG teachers

|  |  |  |
| --- | --- | --- |
| Year | No. of PG students admitted | No. of PG Teachers available in the dept. (give names) |
| Degree | Diploma |
| 2016 |  |  |  |
| 2015 |  |  |  |
| 2014 |  |  |  |
| 2013 |  |  |  |
| 2012 |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 24 | Other PG courses run by the institution  | Course Name | No. of seats | Department |
| DNB |  |  |
| M.Sc. |  |  |
| Others(Superspecialities) |  |  |

25. Whether other medical superspecialty Peadiatric Neurology /Peadiatric endocrinologydepartment exits in the institution …………… Yes/No

 (If yes give details)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of department | Beds/Units | When LOP for DM seats granted & Number of seats | Available faculty (Names & Designation) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*I have physically verified the beds, faculty and patients of above Super specialty departments and they have not been counted in Neonatology. department inspection.*

26**. Stipend paid to the PG students, year-wise:**

|  |  |  |
| --- | --- | --- |
| **Year** | **Stipend paid in Govt. colleges by State Govt.** | **Stipend paid by the Institution\*** |
| Ist Year |  |  |
| IInd Year |  |  |
| IIIrd Year |  |  |

\* **Stipend shall be paid by the institution as per Govt. rate shown above.**

27. List of Departmental Faculty joining and leaving after last inspection:

|  |  |  |
| --- | --- | --- |
| Designations | Number | Names |
| Joining faculty | Leaving faculty |
| Professor  |  |  |  |
| Associate Prof. |  |  |  |
| Assistant Prof. |  |  |  |
| SR/Tutor/Demons. |  |  |  |
| Others |  |  |  |

28. Faculty deficiency, if any

|  |  |  |  |
| --- | --- | --- | --- |
| **Designation** | **Faculty available****(number only)** | **Faculty required** | **Deficiency, if any** |
| Professor |  |  |  |
| Assoc Professor |  |  |  |
| Asstt. Professor |  |  |  |
| Sr. Residents |  |  |  |
| Jr. Residents |  |  |  |
| Tutor/ Demonstrator |  |  |  |
| Any Other |  |  |  |

\* **Faculty Attendance Sheet duly signed by concerned faculty must be enclosed.**

1. **REMARKS OF ASSESSOR**

1. please do not repeat information already provided
2. please do not make any recommendation regarding granting permission/recognition
3. if you have noticed or come across any irregularity during your assessment like fake or dummy faculty, fake or dummy patients, fudging of data of clinical material etc., please mention them here)

**PART – I**

**(Institutional Information)**

1. **Particulars of Director / Dean / Principal**:

 *(Who so ever is Head of Institution)*

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_(*Date of Birth*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PG Degree | Subject | Year | Institution | University |
| *Recognised /* *Not Recognized* |  |  |  |  |

**Teaching Experience**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Designation | Institution | From | To | Total experience |
| Asstt Professor |  |  |  |  |
| Assoc Professor/Reader |  |  |  |  |
| Professor |  |  |  |  |
| Any Other |  | Grand Total |  |

1. **Central Library**
* Total number of Books in library: \_\_\_\_\_\_\_\_\_\_\_\_
* Books pertaining to Neonatology: \_\_\_\_\_\_\_\_\_\_\_\_
* Purchase of latest editions of books in last 3 years: - Neonatologybooks Total\_\_\_\_\_\_\_\_\_\_\_\_
* Journals:

|  |  |  |
| --- | --- | --- |
| Journals | Total | Neonatology |
| Indian |  |  |
| Foreign |  |  |

* Year / Month up to which latest Indian Journals available: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Year / Month up to which latest Foreign Journals available: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Internet / Med pub / Photocopy facility: available / not available
* Library opening times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Reading facility out of routine library hours: available / not available

*(obtain list of books & journals duly signed by Dean)*

1. **Casualty:/ Emergency Department**

|  |  |
| --- | --- |
| Space |  |
| Number of Beds |  |
| No. of cases (Average daily OPD and Admissions): |  |
| Emergency Lab in Casualty (round the clock): | available / not available |
| Emergency OT and Dressing Room |  |
| Staff (Medical/Paramedical) |  |
| Equipment available |  |

**4 Blood Bank**

|  |  |  |
| --- | --- | --- |
| (i) | Valid 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 |
|  |  |  |

**5. Central Research Lab:**

* + Whether it exists? Yes No
	+ Administrative control:
	+ Staff:
	+ Equipment:
	+ Workload:

**6. Central Laboratory:**

* + Controlling Department:
	+ Working Hours:

|  |
| --- |
| **Radiotherapy (Optional)** |
| Radiotherapy |  |
| Teletherapy |  |
| Brachy therapy |  |
|  |  |

**7** Central supply of Oxygen / Suction**:** Available / Not available

**8.** Central Sterilization Department Adequate / Not adequate

**9.** Laundry: Manual/Mechanical/Outsourced:

**10.** Kitchen Gas / Fire

**11.** Incinerator: Functional / Non functional Capacity: Outsourced

**12.** Bio-waste disposal Outsources / any other method

**13.** Generator facility Available / Not available

**14.** Medical Record Section: Computerized / Non computerized

* ICD10 classification Used / Not used

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

|  |  |
| --- | --- |
| In the entire hospital | In the department of Neonatology |
| OPD |  | OPD |  |
| IPD (Total No. of Patients admitted) |  | IPD (Total No. of Patients admitted) |  |
| Deaths |  | Deaths |  |

16. Total Number of Births in the Hospital during the last one year:

*Note: (1) The data be verified by checking the death/birth registration forms sent by the college/hospital to the Registrar, Deaths & Births (Photocopy of all such forms be provided.)*

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

Play grounds Gymnasium

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **18** | **Hostel Accommodation** | UG | PG | Interns |
| Boys | Girls | Boys | Girls | Boys | Girls |
|  | No. of Rooms |  |  |  |  |  |  |
|  | No. of Students |  |  |  |  |  |  |
|  | Status of Cleanliness  |  |  |  |  |  |  |

**19.** Residential accommodation for Staff / Paramedical staff Adequate / Inadequate

**20.** Ethical Committee (Constitution):

**21.** Medical Education Unit (Constitution)

*(Specify number of meetings held annually & minutes thereof)*

**PART – II**

**(DEPARTMENTAL INFORMATION)**

**1 Department inspected :** Neonatology

**2 Date on which independent department ………………………..**

 **of Neonatology was created and started functioning**

 **(Attach copy of order from Govt/Competent Authorities)**

**3 Faculty details (From start of department till date)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Designation** | **PG/ Superspeciality Qualification in concerned subject (Year of Passing, University and College)** | **Appointment/Promotion orders (No…/Date… attach photocopy** | **Salary Details including TDS deducted** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**4 Particulars of present HOD**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_(*Date of Birth*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PG Degree andSuperspecialtydegree | Year of passing |  Institution  | University | Recognized/Not Recognized |
|  MD/Ms |  |  |  |  |
| DM/M.Ch. |  |  |  |  |
| Two years Special Training |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Teaching Experience ( Give Experience in Neonatology – not in Paediatrics)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Designation | Institution | From | To | Total experience |
| Asstt Professor |  |  |  |  |
| Assoc Professor/Reader |  |  |  |  |
| Professor |  |  |  |  |
| Any Other |  | Grand Total |  |

**5 Whether Independent department of Paediatrics Surgery exists in the institution: Yes/No……..**

 **(If yes……………..Since When………………………..)**

**6 (a)Purpose of Present inspection:**

Grant of Permission/ Recognition/ Increase of seats /Renewal of recognition/Compliance Verification

1. **Date of last MCI inspection of the department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Write Not Applicable for first MCI inspection)

c) **Purpose of Last Inspection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**d)Result of last Inspection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (Copy of MCI letter be attached)

**7 Mode of selection** (actual/proposed) of PG students.

**8 If course already started, yearwise number of PG students admitted and available PG teachers during the last 5 years:**

|  |  |  |
| --- | --- | --- |
| Year | No. of PG students admitted | No. of PG Teachers available in the dept. (give names) |
| Degree | Diploma |
| 2016 |  |  |  |
| 2015 |  |  |  |
| 2014 |  |  |  |
| 2013 |  |  |  |
| 2012 |  |  |  |

**9 General Departmental facilities:**

* Total number of beds in the department :…………………………………………..
* Number of Units in the department :………………………………………….
* Unit wise Teaching and Resident Staff (Annexed)………..……………………………

**Unit wise Teaching and Resident Staff:**

 Unit \_\_\_\_\_\_\_\_\_ Bed Strength \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **S. No.**  | **Designation** | **Name with Date of Birth**  | **Nature of employment** **Full time/part time/Hon.** | **PAN Number****TDS deducted** | **PG AND SUPERSPECIALITY QUALIFICATION** | **Experience****Date wise teaching experience with designation & Institution**  | **Signature of Faculty Member**  |
|  |  |  |  |  | **Subject with Year of passing**  | **Institution** | **University** | **Designation****Mentioning subject**  | **Institution** | **From** | **To** | **Total Period** | **\* Benefit of publications given in promotion Yes/No, if yes****List publications here** **(no annexures)** |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

***Note: 1. Unit wise teaching / Resident staff should be shown separately for each Unit in the Proforma.***

***2. Use only the Format provided. DO NOT devise your own format otherwise the information will not be considered. Fill up all columns***

3. \*Publications: Give only full articles in indexed Journals published during the period of promotion and list them here only. No Annexure will be seen.

4. Incase of DNB qualification name of the institution/hospital from where DNB training was done and year of passing must be provided. Simply saying National Board of Examinations, New Delhi is not enough. Without these details DNB qualification holder will be summarily rejected.

5. Experience of Defence services must be supported by certificate from competent authority of the office of DGAFM without which it will not be considered.

 I have verified the eligibility of all faculty members for the post they are holding (**based on experience certificates issued by competent authority of the place of working**). Their experience details in different Designations and unitwise distribution is given the faculty table above.

10 Has any of these faculty members including senior residents been considered in PG/UG inspection at any other college or any other subject in this college in the present academic session. If yes, give details..

|  |  |  |
| --- | --- | --- |
| Date of Inspection | Institution | Subject |
|  |  |  |
|  |  |  |

11 List of Faculty joining and leaving after last inspection:

|  |  |  |
| --- | --- | --- |
| DESIGNATIONS | NUMBER | NAMES |
| JOINING FACULTY | LEAVING FACULTY |
| Professor  |  |  |  |
| Associate Prof. |  |  |  |
| Assistant Prof. |  |  |  |
| SR/Tutor/Demons. |  |  |  |
| Others |  |  |  |

12 List of Non-teaching Staff in the department: -

|  |  |  |
| --- | --- | --- |
| S.No. | Name | Designation |
|  |  |  |
|  |  |  |
|  |  |  |

**13** Available Clinical Material: **(Give the data only for the department of Neonatology)**

On inspection day Average of 3 random day

* Daily OPD …………………. …………………………
* Daily admissions …………………. …………………………
* Daily admissions in Deptt. through casualty …………………. …………………………
* Bed occupancy in the Deptt. …………………. …………………………

Number of patients in ward(IPD) on inspection day…………. …………………………

Percentage bed occupancy

* Weekly clinical work load for OPD & IPD …………………. …………………………
* ABG …………………. …………………………
* Phototherapy …………………. …………………………
* Evoked potentials : CT/MRI …………………. …………………………

MR/Angiograms/carotid Doppler …………………. …………………………

* Biochemistry …………………. …………………………

14 List of equipment available in the department of Neonatology

 Equipments: List of important equipments available and their functional status

 (*list here only – No annexure to be attached)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ABG Equipment |  |  |  |  |  |
| Phototherapy Equipment |  |  |  |  |  |
| Parenteralnutrition Equipment |  |  |  |  |  |
| Paediatric Ventilation  |  |  |  |  |  |
| Endoscopy Paediatric equipment |  |  |  |  |  |
| Dialysis Machine |  |  |  |  |  |
| Peadiatric Bronchoscope  |  |  |  |  |  |

15 Year-wise available clinical materials (during previous 3 years) for department of Neonatology

|  |  |  |  |
| --- | --- | --- | --- |
| **Parameters** | **Year 1** | **Year 2** | **Year 3** |
| Total number of New Patients in OPD |  |  |  |
| Total number of Follow up patients in OPD |  |  |  |
| Total Number of Patients in IPD |  |  |  |
| Weekly clinical work load for IPD (Average weekly Bed occupancy) |  |  |  |
| Investigative workload of the Department and its distribution* ABG
* Serum bilirubin
* X-Rays
* CT/MRI
* Biochemistry
* Neuro-pathology in particular for muscle/Never/Brain
 |  |  |  |
| Average monthly number of special investigations in Neonatology department |  |  |  |

16 Any Intensive care service provided by the department:

17 Specialty clinics being run by the department and number of patients in each clinic

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| S.No. | Name of the Clinic | Days on which held | Timings | Average No. of cases attended | Name of Clinic In-charge |
| 1 | Neuro development Clinic  |  |  |  |  |
| 2 | Well Baby OPD |  |  |  |  |
| 3 | Neonatal &Fetal surgery Combined clinic |  |  |  |  |
| 4 | High risk Neonatal clinic |  |  |  |  |
| 5 | Retinopathy of Prematurityclinic |  |  |  |  |
| 6 | Others |  |  |  |  |

**18. Services provided by the Department.**

|  |  |  |  |
| --- | --- | --- | --- |
| **S.No.** | **Electrophysiology Labs** | **Yes/No** | **If Yes – Weekly Workload** |
| 1 | Neonatal Ventilation  |  |  |
| 2 | Exchange transfusion |  |  |
| 3 | Phototherapy  |  |  |
| 4 | Parenteral nutrition |  |  |
| 5 | Rehabilitation  |  |  |
| 6 | Counseling  |  |  |
| 7 | Others |  |  |

**19** Space

|  |  |  |  |
| --- | --- | --- | --- |
| S.No | Details | In OPD | In IPD |
| 1 | Patient |  |  |
| 2 | Equipments |  |  |
| 3 | Teaching Space |  |  |
| 4 | Waiting area for patients |  |  |

**20** Office space:

|  |  |
| --- | --- |
| **Department Office** | **Office Space for Teaching Faculty**  |
| Spacefor Clerk | Yes/No | HOD |  |
| Staff (Steno /Clerk)  | Yes/No | Professors |  |
| Computer/ Typewriter | Yes/No | Associate Professors |  |
| Storage space for files  | Yes/No | Assistant Professor |  |
|  |  | Residents |  |

**21.** Clinico- Pathological conference

1. Clinico-rediological meetings
2. Neonatology – Paediatric meetings(combined clinic)

***Note : Verify from the maintained register of above said meetings.***

**22**. Submission of data to national authorities if any -

**23. Academic outcome based parameters**

(a) Theory classes taken in the last 12 months – Number \_\_\_\_\_\_\_\_

 (Dates, Subjects, Name & Designation Available & Verified/

of teachers, Attendance sheet) Not available

(b) Clinical Seminars in last 12 months Number \_\_\_\_\_\_\_\_

 (Dates, Subjects, Name & Designation Available & Verified/

of teachers, Attendance sheet) Not available

(c) Journal Clubs held in last 12 months Number \_\_\_\_\_\_\_\_

 (Dates, Subjects, Name & Designation Available & Verified/

of teachers, Attendance sheet) Not available

(d) Case presentations held in last 12 months Number \_\_\_\_\_\_\_\_

 (Dates, Subjects, Name & Designation Available & Verified/

of teachers, Attendance sheet) Not available

(e) Group discussions held in last 12 months Number \_\_\_\_\_\_\_\_

 (Dates, Subjects, Name & Designation Available & Verified/

of teachers, Attendance sheet) Not available

(f) Guest lectures held in last 12 months Number \_\_\_\_\_\_\_\_

 (Dates, Subjects, Name & Designation Available & Verified/

of teachers, Attendance sheet) Not available

**24**. Any other information.

PART III

POSTGRADUATE EXAMINATION

*(Only at the time of recognition inspection)*

1. Minimum prescribed period of training.

*(Date of admission of the Regular Batch appearing in examination)*

1. Minimum prescribed essential attendance.
2. Periodic performance appraisal done or not?
3. Whether the candidates appearing in the examination have submitted their thesis six months before appearing in examination as per PG Regulations.2000?
4. Whether the thesis submitted by the candidates appearing in the examination been accepted or not?
5. Whether the candidates appearing in the examination have (i) presented one poster (ii) read one paper at National/State conference and presented one research paper which has been published/accepted for publication/sent for publication during period of their postgraduate study period.
6. Details of examiners appointed by Examining University (Give details here, No Annexures).
7. Whether appointment of examiners, their eligibility & conduct of examination is as per prescribed MCI norms or not ?
8. Standard of Theory papers and that of Clinical / Practical Examination:
9. Year of 1st batch pass out (mention name of previous/existing University)

Degree Course ------------------

Note: (i) Please do not appoint retired faculty as External Examiner

(ii) There should be two internal and two external examiners. If there are no two internal examiners available in the department then only appoint three external examiners.

(iii) Put NA for those columns not applicable.