**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESMENT FORM – FOR AY 2021-22**

**“A”**

General information pertaining to:

1. College and Teaching Hospital
2. Courses of study leading to

**M.B;B.S.**

**Name of the Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Complete address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the Principal/Dean:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone nos. Off: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Affiliating University: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of assessment:\_ \_ /\_ \_ /\_ \_ \_ \_ Signature of Principal/Dean**

**With Office stamp/Seal**

This form shall be filled precisely and handed over by the Dean/Principal to the convener of the Assessing team. The assessors shall duly verify and examine the entries and send it with their observations to the President, Medical Assessment & Rating Board, National Medical Commission, duly signed and dated. As far as possible, unless otherwise instructed, all the required information should be contained in the form and separate enclosures be avoided. The entries should be as required under the MCI regulations and norms read with section 61(2) of NMC Act, 2019.

**GENERAL INFORMATION**

1. Year of grant of Letter of Permission (LOP): ……………………………………
2. Year of grant of Permission by NMC/MCI: …………………………………….

*[In respect of new medical college/renewal of yearly permission, please attach Letter of Intent, Letter of Permission and yearly approval by NMC/MCI/Central Government]*

1. Management: Government/University/Autonomous body/ Trust/ Society/Company/Consortium.
2. Annual intake: ………… (Students)
3. Year to year increase (if any): .……………………………………………………  
   *[Year and number of admissions permitted by NMC/MCI to be specified and copies of the NMC/MCI approval to be attached]*
4. Year of recognition by the NMC/MCI: ……………………………………………………
   1. Undergraduate: ………………………
   2. Post graduate: …...…………………... Last assessment with date/s: ……………….

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sl.No. | Course | Number of Seats | | |
| Degree/Diploma permitted by NMC/MCI | Degree/Diploma recognized by NMC/MCI | Degree/Diploma not permitted/not recognized by NMC/MCI |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Annual Budget**

1. Pay and Allowances: ……………………………………………………………

*[Please attach separate sheet with pay scales and allowances of all the categories of employees, i.e. teaching staff, technical,administrative and support Staff and so on.]*

1. Contingency: (i) Recurring

(ii) Non-recurring

**Administrative set up for looking after:**

1. **Admissions:**

*[Please attach a copy of the current prospectus of the college/university/Government.]*

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

Name of the Principal/Dean: ……………………………………………..................

Qualifications (College, University and year)………………………………………

|  |  |  |  |
| --- | --- | --- | --- |
| **Teaching Experience** | | **Administrative Experience** | |
| Designation | Duration | Designation | Duration |
| Dean/Principal |  |  |  |
| Professor |  |  |  |
| Associate Professor |  |  |  |
| Assistant Professor |  |  |  |

1. **Accommodation details:**

Principal/Dean’s office size :\_ \_ \_ \_m2

Staff room size :\_ \_ \_ \_m2

College Council room size : \_ \_ \_ \_m2

Office Superintendent room –size : \_ \_ \_ \_m2

Office Space Size : \_ \_ \_ \_m2

Record room size : \_ \_ \_ \_m2

Whether Intercomis available :Yes/No

**WORKING HOURS**

1. No. of actual working days: College:

Hospital:

(ii) Daily working hours:

COLLEGE COUNCIL

1. Composition :
2. Functions:
3. No. of Sessions per year:

BUILDING

1. **Layout & floor area**
2. Year & Cost of construction:
3. Cost of Equipment and Furniture:
4. **Location of Departments:**
5. Pre-clinical
6. Para-clinical
7. Clinical
8. Details of Lecture theatres

|  |  |  |
| --- | --- | --- |
| **Details** | **In the College** | **In the Hospital** |
| Numbers |  |  |
| Type (Gallery/Level) |  |  |
| Seating Capacity of each |  |  |
| A-V aids in each LT |  |  |
| Live streaming capability |  |  |

(e) Auditorium (Capacity):

1. Enumerate teaching areas other than Lecture Theatres available in the following departments (Demonstration rooms etc.)
   1. Preclinical
   2. Paraclinical
   3. Clinical
2. Do all teaching areas including laboratories have live streaming capability? Yes/No

If not, attach a list of areas that do not have live streaming capability?

1. Are any of the teaching areas including Museums shared by two or more departments? Yes/No

If yes, provide a list with details:

1. Examination Hall (Seating capacity)
2. Common rooms:

For Boys: Yes / No If yes, area: \_ \_ \_ \_ m2

For Girls: Yes / No If yes, area: \_ \_ \_ \_ m2

Facilities of attached toilets: Yes /No (If no, reasons thereof)

1. Central Laboratories (Provide details in a separate sheet where required):
2. Staff :
3. Equipment:
4. Coordinating department:

CENTRAL LIBRARY

(a) Layout and floor area :

(b) Reading Rooms (mention seating capacity of each):

1. for UG students. :
2. for PG students :
3. for Staff :

(c) Working hours :

(d) No. of shifts :

(e) Number of books :

|  |  |  |
| --- | --- | --- |
| 1 | Text books |  |
| 2 | Reference books |  |
| 3 | e-books |  |

1. Number of Journals subscribed annually

|  |  |  |
| --- | --- | --- |
|  | National | Foreign |
| Hard copy |  |  |
| e-journal |  |  |
| Total |  |  |

1. Number of Journals actually received annually

|  |  |  |
| --- | --- | --- |
|  | National | Foreign |
| Hard copy |  |  |
| e-journal |  |  |
| Total |  |  |

(h) Number of back volumes of Journals

|  |  |  |
| --- | --- | --- |
|  | National | Foreign |
| Hard copy |  |  |
| e-journal |  |  |
| Total |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| (i) Number of books purchased during the last 3 years   |  |  | | --- | --- | | Year 1 |  | | Year 2 |  | | Year 3 |  | |

(j) Details of Staff with qualifications:

**Designation/Category Name Qualifications**

1. Librarian
2. Deputy librarian
3. Library assistants
4. Other staff
5. System of Cataloguing:
6. Whether Library areas are air-conditioned?: Yes / No

If not, provide details and/or reasons

**MEDICAL EDUCATION UNIT:**

|  |  |
| --- | --- |
| **Staff** | **Numbers** |
| Hon. Director/Coordinator |  |
| Honorary Faculty |  |
| Support staff |  |
| Stenographer |  |
| Computer operator |  |
| Technical staff |  |
| Any other staff |  |

1. Equipment available
2. Teaching & training material available
3. No. of training courses conducted by Medical EducationUnit (Attach Details)
4. Categories of personnel trained
5. Number trained in each category

**HEALTH CENTRES – RURALand URBAN**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sl.** | **Particulars** | **RHC/PHC** | **UHC** |
|  | Name of center: |  |  |
|  | Location of center: |  |  |
|  | Population covered: |  |  |
|  | Distance from college&Travel time |  |  |
|  | Transport facilities for the following |  |  |
|  | 1. Students + Interns |  |  |
|  | 1. Staff |  |  |
|  | 1. Support staff |  |  |

(f) Staff of the Centers:

1. Hostel facilities at the Rural Health Centers:
2. Whether Messing facilities available: Yes / No

(i) working arrangement / Administrative control of Health Centers:

(i) Total (Administrative& Financial) control with the college

(ii) Partial (Academic) control

HOSTELS

(a) Layout :

(b) Distance from the college &Hospital :

(c) Total No. of rooms &occupancy/seats: \*Mention Area of each type of room

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category** | | **No. of Rooms** | | |
| **Single** | **Double** | **Three or more** |
| Undergraduate | Boys |  |  |  |
| Girls |  |  |  |
| \*Area (m2) |  |  |  |
| Postgraduate | Gents |  |  |  |
|  | Ladies |  |  |  |
|  | \*Area (m2) |  |  |  |

1. Number of students on the roll :

Percentage of Students accommodated :

(e) Supervisory arrangement :

(f) Messing & canteen arrangements :

(Dining hall should have accommodation for 25% of all occupants at a given time).

(g) Availability of room, reading room TV room and indoor games

**RESIDENTIAL ACCOMMODATION/QUARTERS :**

(a) Categories :

(b) Number :

(c) Percentage of Staff accommodated in each category :

**SPORTS AND RECREATION FACILITIES :**

(a) Number of playgrounds and games played :

(b) Gymnasium facilities and arrangements :

(c) Sports Officer/Physical instructor :

**TEACHING HOSPITAL (MAIN & SUBSIDIARY)**

(a) Management: Govt./Autonomous/Trust/Society/University/Company/Consortium

(b) Number of years for which the hospital has been fully functional:

1. Administrative set up:
2. Particulars of Hospital/Hospitals:
3. Name of the Hospital:
4. Total number of teaching beds:
5. Number of special/paying wards:
6. Medical Superintendent:

|  |  |  |
| --- | --- | --- |
| **Name &qualifications** | **Teaching/Non-teaching** | **Telephone numbers: Off/Res** |
|  |  |  |
|  |  |  |

1. Medical Superintendent’s Office – Size
2. Hospital office space – size
3. Nursing superintendent office space – size
4. Waiting area for visitors – size
5. Particulars of Common services / facilities
6. Enquiry/office – Size
7. Gender cell (Committee against sexual harassment)
8. Grievance redressal Cell for Underprivileged and Minorities
9. RTI drop-box (In government institutions only)
10. Reception area – Size
11. Store rooms – Nos. & Size
12. Central Medical Record Section– Size
13. Linen rooms – Nos. & Size
14. Hospital & Staff Committee Room – Size

(d) Indoor Facilities (in each ward)

1. Nurses duty room available with each ward
2. Examination & Treatment Rooms
3. Store Room for linen & equipment
4. Resident doctor’s duty room
5. Student’s duty room

**DISTRIBUTION OF BEDS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Specialty** | **Total Numberof teaching**  **BedsUnits** | | **Average Bed occupancy perday (% of teaching beds)** |
| **(a)** | **Medicine & allied specialties** |  |  |  |
| (i) | Gen. Medicine |  |  |  |
| (ii) | Pediatrics |  |  |  |
| (iii) | Respiratory Medicine |  |  |  |
| (iv) | Dermatology |  |  |  |
| (v) | Psychiatry |  |  |  |
|  | **Total** |  |  |  |
| **(b)** | **Surgery & allied specialties** |  |  |  |
| (i) | Gen. Surgery |  |  |  |
| (ii) | Orthopedics |  |  |  |
| (iii) | Ophthalmology |  |  |  |
| (iv) | Oto-rhino-laryngology |  |  |  |
|  | **Total** |  |  |  |
| **(c)** | **Obstetrics & Gynecology** |  |  |  |
| **(d)** | **Emergency department** |  |  |  |
|  | **Grand Total** |  |  |  |

**ANNUAL BUDGET OF THE HOSPITAL** (**For the past 3 years)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | I | II | III |
| 1. Pay of Staff &establishment | : | : | : |
| 1. Medicine &Stores | : | : | : |
| 1. Diet | : | : | : |
| 1. Non-recurring contingency | : | : | : |

**CLINICAL MATERIAL (HOSPITAL WISE)***[attach a separate sheet if necessary]*

**Outdoor – Average Daily patient Attendance (In figures and words)**

1. Old Patients :
2. New Patients :
3. Total :

**Indoor patient details:**

1. Number of Annual admissions :
2. Average daily bed occupancy :

(% of Teaching beds)

**TEACHING/TRAINING FACILITIES (DEPARTMENT WISE)**

1. In O.P.D.
2. In Indoor

REGISTRATION, MEDICAL RECORDS & STATISTICS DEPARTMENT

(a) Central and/or Departments :

(i) For in-patients :

(ii) For O.P.D. :

(b) Staff :

Medical Record Officer :

Statistician :

Other staff :

Peons :

(c) System of Indexing :

Computerized /Manual :

**EMERGENCYDEPARTMENT/CENTRAL CASUALTY SERVICES**

1. Whether fully functional/working: Yes / No
2. Accommodation for staff on duty:
3. Doctors:
4. Nurses:
5. Students:
6. Other paramedical staff:
7. No. of emergency beds in emergency department/casualty services
8. Working arrangement of emergency department/casualty services
9. Number of emergency department/casualtymedical officers
10. Consultantsservices\*

\*Nature of services

1. Facilities for:
   1. Trauma: Yes / No
   2. Burns: Yes / No
   3. Medical: Yes / No
   4. Surgical: Yes / No
   5. Obstetrics: Yes / No
   6. Pediatrics: Yes / No
2. Average daily attendance of patients
3. Resuscitation and triage services facilities:
4. Oxygen supply – Central Yes /No
5. Ventilators
6. Defibrillator
7. Fully equipped disaster trolleys
8. Facilities provided:
9. X-ray
10. Operation theatre
11. Laboratory facilities
12. Ambulance service Yes/No If yes, Numbers:
13. Whether facilities for medico-legal examination exist or not?

If yes, whether separate staff is posted or not?

CLINICAL LABORATORIES

Numbers Specialty

1. Central
2. Departmental
3. Total number of investigations: (Provide Daily average)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Area | Biochemistry | Clinical Pathology | Microbiology | Any Others |
| 1. OPD |  |  |  |  |
| 1. In patient |  |  |  |  |

1. Bio Safety Laboratory (BSL-II):

(e) Staff & Supervision in each Laboratory

1. Teaching Staff Number :
2. Non-teaching Staff Number :

(f) Equipment in each laboratory:

***[Mention if any of the above laboratory services are outsourced]***

OPERATION THEATRE UNIT

1. Operation theatres:
2. Number
3. Arrangements and distribution
4. Equipment (including anesthesia equipment – attach list)
5. Facilities available in each OT unit (Yes / No).

(i) Waiting room for patients Yes / No

(ii) Soiled Linen room Yes / No

(iii) Sterilization room Yes / No

(iv) Nurses duty room Yes / No

(v) Surgeons &Anesthetist rooms:

* For Males Yes / No
* For Females Yes / No

(vi) Assistants room Yes / No

(vii) Store room Yes / No

1. Washing room for surgeons & Assistants: Yes / No
2. Arrangement for anesthesia
3. Pre-anestheticcare:
4. Post-anesthetic care:
5. Pre-operative ward (number of beds):
6. Post-operative ward (number of beds):
7. Resuscitation facilities and special equipment:
8. If any super specialty exists (Give details):

|  |  |  |
| --- | --- | --- |
| Intensive care Area | No. of beds | Specialized equipment in each |
| ICU |  |  |
| ICCU |  |  |
| Burns ICU |  |  |
| Surgical ICU |  |  |
| Respiratory ICU |  |  |
| Pediatric/Neonatal ICU |  |  |
| Emergency dept ICU |  |  |
| Any other ICU |  |  |

1. Labor Rooms
   1. Clean with number of beds :
   2. Septic with number of beds :

**RADIOLOGICAL FACILITIES**

**(a) Radio Diagnosis**

No. of rooms & their Size :

**Machine** **Strength** **Fixed**  **Mobile**

**(b) Workload per day** **Nos./day Outsourced (Yes/No)\***

1. X-Rays
2. Special procedures (IVP etc.)
3. Ultrasonography
4. C.T. Scans
5. MRI scans
6. Any other like mammographsetc

***[\*Mention if any of the above radio-diagnosis services are outsourced]***

**(c) Protective Measures** -

* + Compliant with AERB regulations:Yes/No
  + PNDT compliance – Yes / No

PHARMACY

(a) Supervised by:

(b) Qualification of pharmacist In-charge:

(c) No. of other staff

(d) No. of prescription dispensed a day

1. Inpatient
2. Out-patient.

***[Mention if the Pharmacy services are outsourced/Owned and run by college]***

CENTRAL STERLIZATION SERVICES DEPARTMENT :

(a) Central or Central and separate satellite CSSD units:

(b) Equipment scope and in-service arrangement:

(c) Volume of work/day:

(d) Arrangement for sterilization of mattresses &blankets:

1. Staff available in CSSD:
2. CSSD In-charge
3. Technical Assistants
4. Technicians
5. Sanitation staff

LAUNDRYFacilities:Provide details

*[****Mention if the Laundry services are outsourced/Owned and run by college]***

KITCHEN: (Type of Arrangements): Provide details

***[Mention if the Kitchen services are outsourced/Owned and run by college]***

CANTEEN

* 1. For Faculty :
  2. For Students :
  3. For Staff :
  4. For Patients :

***[Mention if the above Canteen services are outsourced/Owned and run by college]***

BIOMEDICAL WASTE DISPOSAL:Details of Arrangement

***[Mention if the BMWD services are outsourced/Owned and run by college]***

PARA MEDICAL/OTHER SERVICES STAFF IN THE HOSPITAL

|  |  |  |
| --- | --- | --- |
| Designation | No. of sanctioned posts | Nos. in position |
| 1. Nursing Superintendent |  |  |
| 1. Dy. Nursing Superintendent |  |  |
| 1. Matron |  |  |
| 1. Asst. Nursing Superintendent |  |  |
| 1. Nursing Officers |  |  |
| 1. Lab. Technicians |  |  |
| 1. Lab Assistants |  |  |
| 1. Lab Attendants |  |  |
| 1. Ward boys |  |  |
| 1. Sanitation staff |  |  |
| 1. Any other Category |  |  |

***[Mention if any of the above services/staff are outsourced]***

RESIDENTIAL ACCOMODATION

|  |  |  |  |
| --- | --- | --- | --- |
|  | Category | Nos. Sanctioned | Nos. provided accommodation |
| (i) | Residents |  |  |
| (ii) | Nurses |  |  |
| (iii) | Other Staff |  |  |

***[Mention if accommodation is outsourced/Owned and run by college]***

Percentage of staff provided with quarters

1. Teaching :
2. Non-teaching :

INTERCOM SYSTEM IN THE HOSPITAL CAMPUS

Intercom - Present/ Absent

DMMP SYSTEM IN THE HOSPITAL CAMPUS

DMMP-II – Present/ Absent

CCTVSYSTEM IN THE HOSPITAL CAMPUS

CCTV – Present/ Absent

ACADEMIC INFORMATION OF THE COLLEGE

Result of MBBS examinations – give number and percentage of passes of proceeding 3 years

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Batch | Year 20\_ \_ | | | | Year 20\_ \_ | | | | | | | | Year 20\_ \_ | | | | |
| I MBBS | Regular | | Supplem. | | Regular | | | | | Supplem. | | | Regular | | | Supplem. | |
| No. | % | No. | % | No | | % | | | No. | | % | No. | % | | No. | % |
| Candidates appeared |  | |  | |  | | | | |  | | |  | | |  | |
| Candidates passed |  |  |  |  |  |  | | | |  |  | |  | |  |  |  |
| II MBBS | Regular | | Supplem. | | Regular | | | | | Supplem. | | | Regular | | | Supplem. | |
| No. | % | No. | % | No. | | % | | | No. | | % | No. | % | | No. | % |
| Candidates appeared |  | |  | |  | | | | |  | | |  | | |  | |
| Candidates passed |  |  |  |  |  |  | | | |  |  | |  | |  |  |  |
| Final MBBS – Part I | Regular | | Supplem. | | Regular | | | | | Supplem. | | | Regular | | | Supplem. | |
| No. | % | No. | % | No. | | % | | | No. | | % | No. | % | | No. | % |
| Candidates appeared |  | |  | |  | | | | |  | | |  | | |  | |
| Candidates passed |  |  |  |  |  | | |  | |  |  | |  | |  |  |  |
| Final MBBS – Part II | Regular | | Supplem. | | Regular | | | | | Supplem. | | | Regular | | | Supplem. | |
| No. | % | No. | % | No. | | % | | | No. | | % | No. | % | | No. | % |
| Candidates appeared |  | |  | |  | | | | |  | | |  | | |  | |
| Candidates passed |  |  |  |  |  | | | |  |  |  | |  | |  |  |  |

OTHER INFORMATION:

* + - 1. Yearly research publications\* by the teaching staff (past 3 years)

Ist Year IInd Year IIIrd Year

National journals (No.) :

Foreign journals (No.) :

\*Publication as per NMC/MCI requirements

Ist Year IIndYear IIIrd Year

1. Seminars/Conferences/workshops

CME/Others conductedby the

Institution in last 3 years

3. Awards/recognition received

by the college Faculty :

4. Courses other than MBBS and PG courses being run by the college management: Yes/ No.

Are they being run in the same campus/area demarcated for Medical College: Yes/No.

If yes, (provide details)

|  |  |  |
| --- | --- | --- |
| Name of Course | Full Address of college | No. of Admissions/year |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Total No. of PG students admitted year-wise (previous 3 years)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sl.No | Subjects (Diploma/Degree) | No. of PG students admitted | | |
|  |  | 1st year | 2nd year | 3rd year |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. Are the College and Hospital areas accessible to persons with disabilities? Yes / No
2. Are Fire Safety facilities in place in all buildings ? Yes / No

Details of Fee structure for various courses run by the college:

(Attach separate sheet with details, signed by the college management)

Date of Assessment: \_ \_ /\_ \_ /\_ \_ \_ \_ Signature ofDean/Principal

with official seal/stamp

**(SIF B-1)**

**NATIONAL MEDICAL COMMISISON**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**ANATOMY**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ………………………….…………………………….

**Name of the Head of the Department** …………..….……………………………….

Signature of the Dean/Principal Signature of the

(with seal) Head of the Department

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficienciespointed out in the last Assessment To what extent rectified

1. **Teaching Staff:**In case this space is insufficient, a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Anatomy**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates&where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

(continued on next page)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

1. **List of non-teaching staff: Name(s) of staff members**
2. Technical Assistant
3. Technicians
4. Dissection Hall Attendants
5. Steno typist
6. Store Keeper – cum – clerk
7. Any other category
8. Give the various sub-sections in the Department, if any, like Gross Anatomy, Neuro-Anatomy, Embryology and Histology.

* Is the teaching staff rotated in these sections and if so up to what level

**D. BUILDINGS:**

1. **Demonstration Room :**
2. Number
3. Accommodation (of each demonstration room)
4. Size
5. Capacity

c) Audio-visual equipment available.

ii) **Departmental Library-cum-Seminar Room:**

1. Is there a separate departmental library?

b) Accommodation

i) Size :

ii) Capacity :

c) Number of books and e-books in Anatomy and allied subjects :

d) List of Journals and e-journals :

(iii) **Practical Laboratories** :

**A) Dissection Hall**

a) Accommodation :

i) Size :

ii) Capacity :

1. Number and arrangement of tables

i) Big :

ii) Small :

1. Hygiene and Drainage facilities for Disposal of Discarded parts.
2. Mode of disposal of discarded parts
3. Washing arrangement :

No. of wash basins provided :

1. No. of lockers provided for students :
2. Lighting and exhaust arrangements :
3. Special Instruments other than routine Dissection sets

(such as Electric saw etc.)

1. Extra Learning Aids provided in the Dissection Hall :

(Skeleton, Charts, Black Board etc.)

1. Cadaver Preservation Facilities :
2. Embalming room

* Size
* Location

1. Storage Tanks

* Number
* Size

1. Cold room/cooling cabinets

* Size
* Capacity

1. No. of Cadavers available
2. No. of students allotted per cadaver
3. **Histology Laboratory**
4. Accommodation
   * Size
   * Capacity
5. Working arrangement
   1. Seats available
   2. Cupboard for storage of microscope slides etc.
   3. Number of Microscopes
   4. Number of students to each Microscope
6. Preparationroom
   * Size
   * Location
7. Whether Laboratory Manuals kept by students? Yes/No
8. Close circuit TV/Demonstration Microscope/any other teaching aids :

**(iv) Research Laboratory**

1. Size
2. Equipment

c) Are there any students taken for M.S. or M.Sc. or Ph.D in Anatomy?If so how many per year during the last three years?

1.

2.

3

d) List of publications by the members of the staff ONLY during the last 3 precedingyears as per NMC/MCI requirements?

1. Current areas of Research
2. Do undergraduate students participate in Research?
3. Does the department have an Electron Microscope?

V) **Museum :**

a) Size :

b) Howmany specimens :

c) No. of catalogues of the specimens available to the students.

d) Specimens in Embryology, Neuro-Anatomy, Histology, Gross Anatomy

1. Display of Microscopic sections of normal developing tissues – system wise.
2. Are the microscopic sections of the specimens available for study to the students.
3. Numberof Microscope & X-ray view Boxes available to students in the Museum.
4. List of exhibits other than the specimens.
5. Radiological & specialized imaging exhibits :

* Number
* Type

1. Charts, Skeletons etc.
2. Seating arrangement for students

* Number
* Type

1. Preparation and storage rooms
2. Attached rooms

**(VI) OFFICE ACCOMMODATION**

a) Professor and HOD :

b) Associate Professors/s :

c) Asst. Professors/s :

d) Tutors/Demonstrators/Senior Residents :

e) Non-teaching and clerical staff :

E) **TEACHING PROGRAMME :**

1. **Competency Based UG Curriculum implementation**

|  |  |
| --- | --- |
| **Teaching Methods** | **No. of sessions** |
| * 1. Lectures |  |
| * 1. Small Group Teaching |  |
| * 1. DOAP sessions |  |
| * 1. Practical |  |
| * 1. Bedside teaching |  |
| * 1. Group activity |  |
| * 1. Integrated sessions |  |
| * 1. Any other (specify) |  |

2. **Any other /innovations (specify)** :

1. **Assessment Methods used**
2. Theory: Essay
   1. Essay
   2. Short answer
   3. MCQs
3. OSCE
4. Skill assessment
5. Viva
6. Any other (specify)

(Time table of teaching schedulesto be given).

1. List of Faculty who have undergone Basic/Revised Basic Medical Education training

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

Signature of Head of the Department

**(SIF B-2)**

**NATIONAL MEDCIAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**PHYSIOLOGY**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

**Signature of the Dean/Principal Signature of the Head of the**

**(with seal) Department**

(This form shall first be filled by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessors, who shall examine the information already furnished & gather additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficienciespointed out in the last Assessment / To what extent rectified

1. **Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Physiology**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

1. **List of non-teaching staff: Name (s) of staff members**
2. Technical Assistant
3. Technicians
4. Store Keeper-cum-Clerk
5. Laboratory Attendant
6. Steno-typist
7. Any other category
8. **Buildings:**

(i) **Demonstration Room:**

1. Number

b) Accommodation of each demonstration room:

* Size
* Capacity

1. Audio-Visual equipment available:
2. **Practical Laboratories:**
3. Accommodation **Clinical Physiology Lab Hematology Lab**
4. Size
5. Capacity
6. Working arrangement
7. Seats available : :
8. Water supply : :
9. Sinks : :
10. Electrical Points : :
11. Cupboard for storage of

Microscopes, slides etc : :

1. Main Equipment available
2. Number of Microscopes
3. No. of students to each microscope

f) Preparation room :

1. Size
2. Location

g) Whether Lab Manuals kept by students:

h) Close circuit TV/demonstration   
Microscope/any other teaching aids.

**III) DEPARTMENTAL LIBRARY-CUM-SEMINAR ROOM :**

Is there a separate departmental library?

1. Accommodation
2. Size
3. Capacity
4. Number of Books and e-books in Physiology :
5. List of Journals and e-journals :

**IV) RESEARCH LABORATORY :**

1. Size
2. Equipment
3. Are there any students taken for M.D. or M.Sc. or Ph.D in Physiology?If so how many per year during the last three years?

1.

2.

3.

1. List of publications by the members of the staff ONLY during the preceding 3 years as per NMC/MCI requirements. Attach separate sheet if required.
2. Current areas of Research
3. Do Undergraduate students participate in research?
   * 1. **OFFICE ACCOMMODATION**

a) Professor and HOD :

b) Associate Professors/s :

c) Asst. Professors/s :

d) Tutors/Demonstrators/Senior Residents :

e) Non-teaching and clerical staff:

**D. TEACHING PROGRAMME :**

* + 1. **Competency Based UG Curriculum implementation**

|  |  |
| --- | --- |
| **Teaching Methods** | **No. of sessions** |
| * 1. Lectures |  |
| * 1. Small Group Teaching |  |
| * 1. DOAP sessions |  |
| * 1. Practical |  |
| * 1. Bedside teaching |  |
| * 1. Group activity |  |
| * 1. Integrated sessions |  |
| * 1. Any other (specify) |  |

1. **Any other /innovations (specify)** :
2. **Assessment Methods used**
3. Theory:
   1. Essay
   2. Short answer
   3. MCQs
4. OSCE/OSPE
5. Skills assessment
6. Viva-voce
7. Any other (specify)

(Time table of teaching schedulesto be given).

1. List of Faculty who have undergone Basic/Revised Basic Medical Education training.

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

Signature of Head of the Department

**(SIF B-3)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**BIOCHEMISTRY**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

Signature of the Dean/Principal Signature of the

(with seal) Head of the Department

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficiencies pointed out in the last assessment/ To what extent rectified

* + 1. **Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Biochemistry**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. LIST OF NON-TEACHING STAFF:Name (s) of staff members**

* 1. Technical Assistant

1. Technicians
2. Store Keeper-cum-Clerk
3. Laboratory Attendance
4. Any other category

**C. BUILDINGS:**

(i) **Demonstration Room:**

a) Number

1. Accommodation
2. Size
3. Capacity

c) Audio-Visual equipment available:

**II) PRACTICAL CLASS ROOM/LABORATORIES:**

1. Accommodation
2. Size
3. Capacity
4. Working arrangement
5. Seats available
6. Water supply
7. Sinks
8. Electric points
9. Cupboard for storage of microscopes
10. Preparation room
11. Size
12. Capacity
13. Whether laboratory manual kept by students: Yes / No
14. Close circuit T.V./Any other teaching aids.

**(III) DEPARTMENTAL LIBRARY-CUM-SEMINAR ROOM:**

1. Is there a separate departmental library?
2. Accommodation
3. Size
4. Capacity

c) Number of Books in Biochemistry and allied subjects.

d) List of Journals

**(IV) RESEARCH LABORATORIES**

a)Size

b) Equipment

c) Are there any students taken for M.D. or M.Sc. or Ph.D in Biochemistry?If so how many per year during the last three years?

1.

2.

3.

d) List of publications by the members of the staff ONLY during the preceding 3years as per MCI/NMC requirements?

e) Current areas of Research

f) Do Undergraduate students participate in research?

1. **OFFICE ACCOMMODATION**

a) Professor and HOD :

b) Associate Professors/s :

c) Asst. Professors/s :

d) Tutors/Demonstrators/Senior Residents:

e) Non-teaching and clerical staff :

**D. TEACHING PROGRAMME :**

* + 1. Competency Based UG Curriculum implementation

|  |  |
| --- | --- |
| **Teaching Methods** | **No. of sessions** |
| * 1. Lectures |  |
| * 1. Small Group Teaching |  |
| * 1. DOAP sessions |  |
| * 1. Practical |  |
| * 1. Bedside teaching |  |
| * 1. Group activity |  |
| * 1. Integrated sessions |  |
| * 1. Any other (specify) |  |

* + 1. Any other /innovations (specify) :
    2. Assessment Methods used

1. Theory:
   1. Essay
   2. Short answer
   3. MCQs
2. OSCE
3. Skill assessment
4. Viva
5. Any other (specify)

(Time table of teaching schedules to be given).

* + 1. List of Faculty who have undergone Basic/Revised Basic Medical Education training

**E. SERVICE LABORATORY IN THE TEACHING HOSPITAL/COLLEGE:**

1. Is there separate biochemistry laboratory in the hospital? Yes/No
2. If yes, control and supervision

i) Whether departmental (college)

ii) Under Medical Superintendent (Hospital)

iii) If departmental, method of posting and rotation of medical & non-medical staff

1. Size of the laboratory:
2. Investigative equipment available (Attach list)

e) Staff **Names Qualifications Designation**

1.Medical

2. Non-Medical

### Report giving details of work done during the last 1 year to be attached:

1. Are the students (UG/PG) posted in the hospital laboratory? Yes/No

**F. IS THERE ANY EMERGENCY HOSPITAL BIOCHEMISTRY SERVICE**

If so give details of

1. Staff employed
2. Average no. of tests done during one month (in emergency laboratory)
3. Is a record of these test maintained

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

Signature of Head of the Department

**(SIF B-4)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**PATHOLOGY**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** ……………………………………………….

Signature of the Dean/Principal Signature of the

(with seal) Head of the Department

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors:

Deficiencies pointed out in the last assessment/ To what extent rectified

1. **Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Pathology**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. LIST OF NON-TEACHING STAFF: Name (s) of staff members**

1. Technical Assistant
2. Technicians
3. Laboratory Attendants
4. Steno-typist
5. Store Keeper
6. Any other category

**C.** Give the various sub-section in the department like Morbid Anatomy, Histopathology, Cytopathology, Clinical Pathology/Hematology and any other specialized section.

Is the teaching staff rotated in these sections?

If so, upto what level?

1. **BUILDINGS:**

(I) Demonstration Room:

1. Number
2. Accommodation

* Size
* Capacity

1. Audio-Visual equipment available
2. **PRACTICAL LABORATORIES:**

**MorbidAnatomy/ Clinical Pathology Histopathology/ /Hematology**

**Cytopathology**

**---------------------------------------------------------------------------------------------------------**

1. Accommodation
2. Size
3. Capacity
4. Working arrangement
5. Seats available
6. Water supply
7. Sinks
8. Electrical Points
9. Cupboard for storage of microscopes etc.
10. Main Equipment available
11. Number of Microscopes
12. No. of students to each microscope :
13. Preparation room:
14. Size
15. Location

g) Whether Laboratory Manuals kept by students? Yes / No

h) Close circuit TV/demonstration Microscope/any other teaching aids.

1. **Service Laboratory in the teaching hospital/college:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Particulars** | **Histopathology** | **Cytopathology** | **Hematology** | **Any others** |
| Are there separate laboratories |  |  |  |  |
| Control and supervision (Dept or MS)\* |  |  |  |  |
| Size of laboratory (m2) |  |  |  |  |
| Equipment available Yes/No (attach list) |  |  |  |  |
| Staff details (in separate tables below) |  |  |  |  |
|  |  |  |  |  |

\* If under departmental control, give details of method of posting and rotation of medical and non-medical staff

|  |  |  |  |
| --- | --- | --- | --- |
| **Histopathology laboratory** | | | |
| Staff details | Name | Qualification | Designation |
| Medical |  |  |  |
| Non-medical |  |  |  |
| **Cytopathology laboratory** | | | |
| Staff details | Name | Qualification | Designation |
| Medical |  |  |  |
| Non-medical |  |  |  |
| **Hematology laboratory** | | | |
| Staff details | Name | Qualification | Designation |
| Medical |  |  |  |
| Non-medical |  |  |  |
| **Other specialized laboratories** | | | |
| Staff details | Name | Qualification | Designation |
| Medical |  |  |  |
| Non-medical |  |  |  |

f) Attach details of work done in each service laboratory during the past 1 year separately.

1. Are the students (UG/PG) posted in the hospital laboratories: Yes / No

**(iv) Is there any emergency hospital Pathology service? Yes / No**

If YES, give details of:

1. Staff employed
2. Average no. of investigationsdone during the past one monthin emergency hospital pathologylaboratory:
3. Is a record of these investigations maintained?
4. **Is there a separate**
5. Balance room Yes /No
6. Store room Yes /No
7. High speed centrifuge room Yes /No
8. **MUSEUM :**
9. Size
10. How are specimens arranged? Give details
11. Give number of each:
12. Mounted specimen
13. Unmounted specimen
14. Are the sections(microscopy slides) of specimens available tothe students for academic purposes? Yes / No

If Yes, are they made available in the museum or some other room or laboratory

1. No. of microscopes available to the students in the museum:
2. Attach list of charts, photographs, models and other exhibits other than the specimens and their arrangements.
3. No. of catalogues of the specimens available to the students.
4. Seating arrangement for students –
5. Type
6. Number
7. **DEPARTMENTAL LIBRARY-CUM-SEMINAR ROOM :**
8. Is there a separate departmental library?
9. Accommodation
10. Size
11. Capacity
12. Number of books in Pathology and allied subjects.
13. List of Journals
14. **RESEARCH LABORATORY:**
15. Size
16. Equipment
17. Are there any students taken for Diploma in Pathology, M.D. or Ph.D. in Pathology?If so, how many per year during the last three years.

1.

2.

3.

1. List of publications by the members of the staff ONLY during the preceding 3years as per MCI/NMC requirements:

e) Current areas of Research

f) Do Undergraduate students participate in research?

**X) OFFICE ACCOMMODATION**

1. Professor & H.O.D.
2. Associate Professor/
3. Asst. Professor/s
4. Tutors/Demonstrators/Senior Residents
5. Non-teaching and Clerical Staff
6. **BLOOD BANK**
7. Is there a blood bank in the hospital? Yes / No
8. If yes, is it approved and licensed by competent authority? Yes / No

Please mention the validation period of the license:

1. Is the blood bank air-conditioned? Yes / No
2. Does the blood bank have Component segregation facility? Yes / No
3. Administrative control of Blood Bank is under (Please tick):

Department of Pathology / Medical Superintendent

1. If it is under the administrative control of the department, provide details of method of posting and rotation of Medical and non-medical staff.
2. Average number of units of blood issued per month over the past year:
3. Average number of blood donors per month over the past year
4. Blood bank Staff – details of both medical and non-medical staff.
5. List the number of tests done in the blood bank: Blood grouping, Rh-typing, Cross matching, Hepatitis –B, Hepatitis –C, Syphilis, Malaria, HIV etc. (Report giving details of work done during the last 1 year to be attached).

**E) TEACHING PROGRAMME :**

* + 1. **Teaching Learning Methods Number**

1) Lectures

2) Demonstrations

3) Tutorials

4) Seminars conducted during the year.

5) Practicals

6) Any other teaching/training activities

7) Is there any integrated teaching?

If yes, details thereof.

8) Any innovations in teaching (specify)

* + 1. **Methods of Assessment** :

(Provide details)

(Teaching schedule to be given).

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

Signature of Head of the Department

**(SIF B-5)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**MICROBIOLOGY**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

Signature of the Dean/Principal Signature of the

(with seal) Head of the Department

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficiencies pointed out in the last assessment/ To what extent rectified

* + - 1. **Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Microbiology**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. List of non-teaching staff: Name(s) of staff members**

1. Technical staff
2. Laboratory attendants
3. Store keeper
4. Record Clerk
5. Stenographer
6. Sanitation staff
7. Any other

**C. Buildings:**

(i) **Demonstration Room:**

a) Number

b) Accommodation

* Size
* Capacity

c) Audio-Visual equipment available:

ii) **Practical laboratories:**

a) Accommodation

* Size
* Capacity

b) Working arrangement

* Seats available
* Water supply
* Sinks
* Electric points
* Cupboard for storage of microscopes

c) Main equipment available Yes / No

d) Number of Microscopes

e) Number of students to each microscopes

1. Preparationroom

* Size
* Location

1. Whether laboratory manual kept by students? Yes / No
2. Close circuit T.V./any other teaching aids.
3. **SERVICE LABORATORY IN THE TEACHING HOSPITAL/COLLEGE:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Bacteriology including anerobic** | **Serology** | **Virology** | **Parasitology** | **Mycology** | **TB lab** | **Immunology** | **Any other** |
| Are there separate Service Labs |  |  |  |  |  |  |  |  |
| If yes Control & supervision is under Dept./ MS\* |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Size of the lab |  |  |  |  |  |  |  |  |

\* If departmental control and supervision, attach details of method of Posting and rotation of Medical & non-medical Staff

1. Do you have a BSL II Virology laboratory – Yes /No If Yes, is there RT-PCR machine – Yes / NO
2. Is there investigative material available in the service laboratories – Yes / No. If yes, attach list.
3. Details of staff in the above laboratories

Staff **Names** **Qualifications** **Designation**

1. Medical
2. Non-medical Staff
3. Attach details of workdone during the past 1 year.
4. Are the students (UG/PG) postedin the hospital laboratory. Yes/No
5. **Is there any emergency hospital Microbiology service.**

If so give details:

1. Staff employed
2. Average number of investigations done during the past 1 month in thehospital emergencyMicrobiology laboratory
3. Is a record of these investigations maintained Yes / No

### a) Is there a separate media preparation and st**o**rage area? Yes / No

If yes, size of the preparation and storage area

b) Autoclaving room Yes / No

If yes, size of the autoclaving room

1. Washing and drying room: Yes/No
2. **Departmental Library-cum-Seminar Room :**
3. Is there a separate departmental Library-cum-Seminar room? Yes / No
4. Accommodation
5. Size
6. Capacity
7. Number of Books in Microbiology and allied subjects.
8. List of Journals
9. **RESEARCH LABORATORIES:**
10. Size
11. Provide list of Equipment
12. Are there any students taken for M.D. or M.Sc. or Ph.D. in Microbiology? If yes, how many per year during the last three years.

1.

2.

3.

d) List of publications by the members of the staff ONLY during the preceding 3 years as per MCI/NMC requirements:

1. Current areas of Research
2. Do Undergraduate students participate in research?
3. **OFFICE ACCOMMODATION**
4. Professor and H.O.D.
5. Associate Professor/
6. Asst. Professor/s
7. Tutors/Demonstrators/Senior Residents.
8. Non-teaching and Clerical staff
9. **TEACHING PROGRAMME.**
   * 1. **Teaching Learning Methods Number**

1) Lectures

2) Demonstrations

3) Tutorials

4) Seminars conducted during the year.

5) Practicals

6) Any other teaching/training activities :

7) Is there any integrated teaching?

If yes, details thereof.

8) Any innovations in teaching (specify)

* + 1. **Methods of Assessment**:

Provide details of assessment methods

(Teaching schedule to be given).

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

Signature of Head of the Department

**(SIF B-6)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**PHARMACOLOGY**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

Signature of the Dean/Principal Signature of the

(with seal) Head of the Department

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficiencies pointed out in the last assessment/ To what extent rectified

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Pharmacology**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. List of non-teaching staff: Name (s) of staff members**

a. TechnicalStaff

b. Technicians

c. Store keeper-cum-clerk

d. Steno-typist

e. Laboratory Attendants

f. Any other category

**C. Buildings:**

(i) **Demonstration Room:**

a) Number

b) Accommodation

* Size
* Capacity

c) Audio-Visual equipment available:

**(ii) PRACTICAL LABORATORIES :**

**Computer Assisted Clinical Laboratory Pharmacology**

a) Accommodation

* Size
* Capacity

b) Working arrangement

1. Seats available

c) Main Equipment available

1. Ante-room/preparation room

* Size
* Location

1. Whether Laboratory Manuals maintained by students? Yes / No
2. Close circuit TV/any other teaching aids

(iii) **Museum :**

* 1. Size :
  2. How are the drug sample arranged?
  3. Number of catalogues of the samples available to the students :
  4. Total number of drug samples :
  5. List of charts, photograph and other exhibits and their arrangement
  6. Is there any section depicting “History of Medicine”?

1. **Departmental Library-cum-Seminar Room :**
2. Is there a separate departmental library?
3. Accommodation

* Size
* Capacity

c) Number of Books in Pharmacology?

1. List of Journals
2. **RESEARCH LABORATORIES:**
3. Size
4. Provide list of Equipment
5. Are there any students taken for M.D. or M.Sc. or Ph.D. in Microbiology?If yes, how many per year during the last three years.

1.

2.

3.

d) List of publications by the members of the staff ONLY during the preceding 3 years as per MCI/NMC requirements?

1. Current areas of Research
2. Do Undergraduate students participate in research?
3. **OFFICE ACCOMMODATION**
4. Professor and H.O.D.
5. Associate Professor/
6. Asst. Professor/s
7. Tutors/Demonstrators/Senior Residents.
8. Non-teaching and Clerical staff
9. **TEACHING PROGRAMME.**
   * 1. **Teaching Learning Methods Number**

1) Lectures

2) Demonstrations

3) Tutorials

4) Seminars conducted during the year.

5) Practicals

6) Any other teaching/training activities :

7) Is there any integrated teaching?If yes, details thereof.

8) Any innovations in teaching (specify)

1. **Methods of Assessment**:

Provide details of assessment methods

(Teaching schedule to be given).

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

Signature of Head of the Department

**(SIF B-7)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**FORENSIC MEDICINE**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

Signature of the Dean/Principal Signature of the

(with seal) Head of the Department

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessor :

3. Date of last Assessment :

4. Names of last Assessors :

Deficiencies pointed out in the last assessment/ To what extent rectified

1. **Teaching Staff :**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Forensic Medicine**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Tutor** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. List of non-teaching staff: Name (s) of staff members**

a. Technical Staff

b. Store keeper-cum-clerk

c. Steno-typist

d. Laboratory Attendants

e. Any other category

**C. Buildings :**

(i) **Demonstration Room:**

* 1. Number

1. Accommodation

* Size
* Capacity

c) Audio-Visual equipment available:

**ii) Museum :**

a) Size

b) How are specimens arranged ?

1. Give number of each :

* Mounted specimen
* Unmounted specimen

1. Proto-type fire and other arms.
2. Wax Models
3. Poisons
4. Attach list of charts, photographs, models and other exhibits other than the specimens and their arrangements.
5. No. of catalogues of the specimens available to the students.
6. Seating arrangement for students:

* Type
* Number

1. **Department of Radiology**
2. Do adequate facilities exist for taking skiagrams of living and dead persons.
3. Do adequate facilities in the department of Biochemistry, Histopathology, Bacteriology & Serology exist for Undertaking the examination of medico-legal materials?
4. **Emergency department / Casualty services Department :**
5. Accommodation
6. Are the facilities for reception, Examination, treatment of medico-legal emergencies and cases of poisoning adequate?
7. The number of cases of medico-legal Trauma, Sexual assault, age and poisoning etc. dealt by the emergency department/casualty services during the last one year may be indicated.
8. **Mortuary Block**
9. Distance from the department
10. Size
11. Student observation facilities
12. Level type
13. Gallery type
14. capacity
15. No. of autopsy tables available :
16. Lighting, ventilation and exhaust arrangements :
17. Water supply, drainage, washing arrangements & disposal of waste.
18. Fly proofing
19. Cold room/cooling cabinets:
20. Size
21. Capacity
22. Equipment

j) Number of medico-legal Year Year Year

postmortem done during

the last 3 years :

k) No. ofpostmortems attended by a student

l) Whether record of postmortem Cases kept by students?

1. **Laboratory:**
2. Accommodation

* Size
* Capacity

1. Working arrangement

* Seats available
* Water supply
* Sinks

1. Main equipment available
2. Number of Microscopes
3. Any other teaching aids
4. **Departmental Library-cum-Seminar Room :**
5. Is there separate departmental library?

b) Accommodation

i) Size :

ii) Capacity :

c) Number of books in Anatomy and allied subjects :

d) List of Journals :

**(VIII) Research Laboratory**

a) Size

1. Equipment

c) Are there any students taken for D.F.M./M.D. or Ph.D. in Forensic Medicine?

If so how many per year during the last three years?

1. Diploma
2. Degree

d) List of publications by the members of the staff ONLY during the preceding 3 years as per MCI/NMC requirements?

e) Current areas of Research:

1. Do Undergraduate students participate in research ?

**IX) OFFICE ACCOMMODATION**

a) Professor and HOD :

b) Associate Professors/s :

c) Asst. Professors/s :

d) Tutors/Demonstrators/Senior Residents :

e) Non-teaching and clerical staff :

D) **TEACHING PROGRAMME :**

* + - 1. **Teaching Learning Methods**

**Number**

1) Lectures

2) Demonstrations

3) Tutorials

4) Seminars conducted during the year.

5) Practicals

6) Any other teaching/training activities :

7) Is there any integrated teaching?

If yes, details thereof.

8) Any innovations in teaching (specify)

* + - 1. **Methods of Assessment** :

(Teaching schedule to be given).

Do all teaching areas including laboratories in your department have live streaming capability?

Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

Signature of Head of the Department

**(SIF B-8)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**COMMUNITY MEDICINE**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

Signature of the Dean/Principal Signature of the

(with seal) Head of the Department

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment/ :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficiencies pointed out in the last assessment/ To what extent rectified

1. **Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Community Medicine**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Demonstrator/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. List of non-teaching staff : Name (s) of staff members**

a. Medical Social Worker

b. Technical Assistant

c. Technicians

d. Stenographer

e. Record Clerk

f. Storekeeper.

g. Any other category

**C. STAFF FOR RURAL TRAINING HEALTH CENTRE:**

(including field work and epidemiological studies)

**Name(s) of staff members**

1. Med. Officer of Health/ Asst. Prof
2. Lady Medical officer
3. Medical Social Worker
4. Public Health Nurse
5. Health Assessors
6. Health Educators
7. Technical Assistant
8. Technician
9. Store keeper
10. Record Clerk
11. Any other category

**D) STAFF FOR UBRAN TRAINING HEALTH CENTRE**

(Including field work and epidemiological studies.)

**Name(s) of staff members**

a. Medical Officer of Health/Asst. Professor

b. Lady Medical officer

c. Medical Social Worker

d. Public Health Nurse

e. Health Assessors

f. Health Educators

g. Technical Assistant

h. Technician

i. Store keeper

j. Record clerk

k.. Any other category

**E. BUILDINGS :**

**(i) Demonstration Room :**

1. Number
2. Accommodation (of each demonstration room)

i) Size

1. Capacity

c) Audio-visual equipment available.

1. **Laboratory :**
2. Accommodation

* Size
* Capacity

b) Working arrangement

* Seats available
* Water supply
* Sinks
* Electric points
* Cupboard for storage of microscope, slides etc

c) Number of Microscopes

d) Whether Laboratory Manuals kept by students? Yes/No

e ) Close circuit TV/any other teaching aids.

(iii) **Museum :**

a) Size :

b) How are the specimens arranged? :

c) Give Number of each :

d) Coverage of various fields in Community Medicine by charts, Models etc.

e) No. of catalogues of the specimens available to the students.

f) List of exhibits, Charts, Photographs & other materials and their arrangement.

* 1. Seating arrangement for students
* Type
* Number

1. **Departmental Library-cum-Seminar Room :**
2. Is there a separate departmental library?
3. Accommodation

i) Size

1. Capacity
2. Number of Books in Community Medicine and allied subjects.
3. List of journals
4. **Research Laboratory :**

a) Size

b) Equipment

c) Are there any students taken for DPH/M.D./Ph.D. in Community Medicine?If so how many per year during the last three years?

1.

2.

3.

d) List of publications by the members of the staff ONLY during the preceding 3years as per MCI/NMC requirements?

1. Current areas of Research
2. Do Undergraduate students participate in research ?
3. **OFFICE ACCOMMODATION**

a) Professor and HOD :

b) Associate Professors/s :

c) Asst. Professors/s :

d) Statistician-cum- :

e) Epidemiologist-cum-Asst. Prof. :

f) Tutors/Demonstrators/Senior Residents/Sr. Residents :

g) Departmental Office-cum-Clerical room :

h) Non-teaching staff :

**(vii)HEALTH CENTRES – RURAL and URBAN**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sl.** | **Particulars** | **RHC/PHC** | **UHC** |
|  | Name of center: |  |  |
|  | Location of center: |  |  |
|  | Population covered: |  |  |
|  | Distance from college & Travel time |  |  |
|  | Transport facilities for the following |  |  |
|  | 1. Students + Interns |  |  |
|  | 1. Staff |  |  |
|  | 1. Support staff |  |  |
|  | Number of vehicles |  |  |
|  | Capacity of each vehicle |  |  |
|  | Control of vehicles – Dept/Central |  |  |

(f) Staff of the Centers :

1. Hostel facilities at the Rural Health Centers:
2. Whether Messing facilities available: Yes / No

(i) working arrangement / Administrative control of Health Centers:

(i) Total (Administrative & Financial) control with the college

(ii) Partial (Academic) control

F) **TEACHING PROGRAMME :**

**Teaching Learning Methods Number**

1) Lectures

2) Demonstrations

3) Tutorials

4) Seminars conducted during the year.

5) Practicals

6) Any other teaching/training activities :

7) Is there any integrated teaching?

If yes, details thereof.

8) Any innovations in teaching (specify)

* + 1. **Methods of Assessment** :

(Teaching schedule to be given).

* + 1. **a. Rural Practice Field:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Subject** | **Time Spent** | **Year of the student in Medical College** | Type of instruction | | |
| **Observation** | **Demonstration** | **Participation** |
|  |  |  |  |  |  |

* 1. **Urban Practice Field :**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Subject** | **Time Spent** | **Year of the student in Medical College** | Type of instruction | | |
| **Observation** | **Demonstration** | **Participation** |
|  |  |  |  |  |  |

c) What field visits and of what duration are organized by the department for the following subject and how far the following subjects and how far have the students participated in the program?

1. Vital statistics
2. Environmental sanitation
3. Communicable/non-communicable Diseases.
4. Public Health Laboratory Service
5. Maternal & Child Health & Family Welfare planning
6. School Health Service
7. Others (Specify)

d) Clinical Social Case reviews – How many are reviewed by a student during his/her career in the Medical College – How are the records kept?

e) Study of Family & Community Health Survey

f) Family case studies

* + 1. **TEACHING HOSPITAL**

1. Average no. of students posted at a time:

To which year do they belong?

(a list of posting for clerkship in preventive and social medicine/community medicine may be furnished)

1. Clinical Teaching
2. bedside clinics
3. by whom given
4. How often during a week?
5. Do students write case histories in a prescribed book?
6. Are they corrected, if so by whom?
7. Do students conduct clinical social case reviews by actual visit to the family?

If so, how many and how they are supervised?

1. Are these reviews assessed by the staff of the department?
2. Are there facilities for teaching and demonstration for preventive healthservices in any infectious diseases?
3. If so what type of cases are available for teaching and demonstration and howmuch time is allotted for this during the course of study?
4. Record and filing system at the rural and urban field practice areas.

Are family folders introduced or in the maintenance of records?

1. Outpatient Department
2. Arrangement for case study for students
3. Clinical outpatient teaching
4. No. of demonstrations given by the Community Medicine department in collaboration with other clinical departments in the outpatient department and on what subjects.
5. Is the department running immunization clinic? Yes/No

If yes, frequency per week.

Are Undergraduate students posted in the clinic?

* + - 1. **INTERNSHIP TRAINING**

1. Period of posting in the department
2. Pattern of posting Period
3. Rural Health Centre/Primary Health Centre
4. Urban Health Centre
5. Other postings like

* National Health Programmes
* Clinics
* Immunization
* School Health
* Family Welfare Planning
* Any other postings

1. Method of Assessment for Internship

(Please attach a copy of logbook/assessment sheet).

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

**Signature of Head of the Department**

**(SIF B-9)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**GENERAL MEDICINE**

**INCLUDING RESPIRATORYMEDICINE, DERMATOLOGY& PSYCHIATRY**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

Signature of the Dean/Principal Signature of the

(with seal) Head of the Department

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficiencies pointed out in the last assessment/ To what extent rectified

**Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A1: Department of General Medicine**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A2: Department of Respiratory Medicine**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A3: Department of Dermatology**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A4: Department of Psychiatry**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. List of non-teaching staff :**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Nomenclature** | **Name(s) of staff members** | | | |
| **General Medicine** | **Respiratory Medicine** | **Dermatology** | **Psychiatry** |
| 1. E.C.G. Technician |  |  |  |  |
| 1. Technical Staff |  |  |  |  |
| 1. Lab. Attendants |  |  |  |  |
| e. Steno-typist |  |  |  |  |
| f. Clinical Psychologist |  |  |  |  |
| g. Psychiatric Social Workers |  |  |  |  |
| h. Any other category |  |  |  |  |

**C. BUILDINGS : General Respiratory Dermatology Psychiatry**

**Medicine Medicine**

**(i) Clinical Demonstration Room**

a) Number

b) Accommodation (ofeach)

i) Size

ii) Capacity

c) Audio-visual equipment

available.

1. **Departmental Library-cum**

**Seminar Room:**

1. Is there a separateDepartmental library?
2. Accommodation

i) Size

1. Capacity
2. Number of Books in
3. General Medicine.
4. Respiratory Med.
5. Dermatology.
6. Psychiatry &allied subjects
7. List of Journals
8. **Research Laboratory**
9. Size
10. Equipment
11. Are there any students

taken for Diploma/M.D.

Ph.D. in Gen. Med./

TB & RD/DVD/Psy?

If so how may per year

During the last three years

i) Diploma

1. Degree

1. List of publications by

ONLY the members of the staff

during the preceding 3 years.

**General Respiratory Dermatology Psychiatry**

**Medicine Medicine**

1. Current areas of

Research? (a statement

may be furnished)

1. Do Undergraduate students

participate in research

work?

1. **OFFICE ACCOMMODATION**

a) Professor and HOD :

b) Associate Professors/s :

c) Asst. Professors/s :

d) Registrars/Sr. Residents :

1. Junior Residents
2. Non-teaching&Clerical staff.
3. **TEACHING HOSPITAL**
   * + - 1. **INPATIENT DEPARTMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Inpatient Departments** | **General Medicine** | **Respiratory Medicine** | **Dermatology** | **Psychiatry** |
| * 1. Total number of beds |  |  |  |  |
| * 1. Number of Teaching Beds |  |  |  |  |
| * 1. Numberof Units |  |  |  |  |
| * 1. Unit-wise staff composition with Names, Qualifications and designation | Attach separate sheet | Attach separate sheet | Attach separate sheet | Attach separate sheet |
| * 1. Annual indoor admissions |  |  |  |  |
| * 1. Average bed occupancy per day (% of teaching beds) |  |  |  |  |

**2) INTENSIVE CARE No. of beds Equipment’s available**

1. Intensive Care Unit (I.C.U.)

b) Intensive Coronary Care

Unit (I.C.C.U.)

c) RespiratoryICU

d) Other intensive Care

Areas, if any.

**3) Major Equipment Available in the Department:**  Names of equipment

1. General Medicine
2. Respiratory Medicine
3. Dermatology

d) Psychiatry

1. **OUT-PATIENT DEPARTMENT:**
2. Building – General layout
3. Is outpatient service Department wise
4. Arrangement for clinical Instructions to

student inGen Medicine & Allied specialties

1. Average Daily OPD Attendance **General Medicine Respiratory Medicine Dermatology Psychiatry**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Old Patients
2. New Patients
3. Total

**Teaching and trainingfacilities**

1. **In O.P.D.**
2. Clinical demonstration room:
3. Number of rooms for examining

patients by faculty & residents

1. **In-door**
2. Bedside teaching
3. Clinical demonstration room/

seminar room

**TEACHING PROGRAMME :**

* + 1. **Teaching Learning Methods**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Numbers held in past 1 year** | | | |
| **Gen. Medicine** | **Resp. Medicine** | **Dermatology** | **Psychiatry** |
| 1. Total Clinical postings |  |  |  |  |
| 1. Lectures |  |  |  |  |
| 1. Tutorials |  |  |  |  |
| 1. Demonstrations |  |  |  |  |
| 1. Seminars conducted |  |  |  |  |
| 1. Bed side teaching |  |  |  |  |
| 1. Practical |  |  |  |  |
| 1. Hours spent by students daily in wards for clerkship. |  |  |  |  |
| 1. Average number of students posted at a time for indoor/OPDPostings. |  |  |  |  |
| 1. Do students write case historiesin a prescribed book |  |  |  |  |
| 1. Is clinical work donein the wards by Students assessed Periodically? |  |  |  |  |
| 1. If yes to #11, how often and by whom? |  |  |  |  |
| 1. Total period of attendancein OPD by a student throughout clinical training. |  |  |  |  |
| 1. Is it done concurrently with the inpatients ward postings? |  |  |  |  |
| 1. Who gives them training to attend to emergencies? |  |  |  |  |
| 1. How is the outpatients teaching organized? |  |  |  |  |
| 1. Do students attendClinico-pathological Conferences? |  |  |  |  |
| 1. If Yes, how many (average) timesin a year |  |  |  |  |
| 1. Any other activities? (specify) |  |  |  |  |

1. Any innovations in teaching/learning methods? If Yes, specify
   * 1. **Methods of Assessment** :

(Teaching schedule to be given).

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

* + 1. **Internship Training Programme**

1. Period of postingin the department
2. Method of assessment ofInternship (please attach aCopy of log book/assessment

Sheet)

**Signature of Heads of the Department Signature of Dean/Principal**

General Medicine :

Respiratory Medicine :

Dermatology :

### Psychiatry :

**(SIF B-10)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**PAEDIATRICS**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

Signature of the Dean/Principal Signature of the

(with seal) Head of the Department

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficiencies pointed out in the last assessment/ To what extent rectified

.

* + - 1. **Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Pediatrics**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. List of non-teaching staff: Name (s) of staff members**

1. Child Psychologist
2. Technical Assistant
3. Technician
4. Store Keeper
5. Steno-typist
6. Any other category

**C. Buildings :**

**(i) ClinicalDemonstration Room:**

* 1. Number
  2. Accommodation (of each demonstration room)

i) Size

1. Capacity
2. Audio-Visual equipment available.
3. **Departmental Library – cum- Seminar Room:**
   1. Is there a separate departmental library?
   2. Accommodation

i) Size :

ii) Capacity :

* 1. Number of books in Pediatrics including Neonatology

1. List of Journals :

**iii) Research Laboratory**

1. Size
2. Equipment
3. Are there any students taken for Diploma/M.D. in Pediatrics? If so how many per year during the last three years?
4. Diploma
5. Degree

d) List of publications by the members of the staff ONLY during thepreceding 3years?

e) Current Research areas (a statement may be furnished)

f) Do Undergraduate students in any way participate in Research?

1. **OFFICE ACCOMMODATION**

a) Professor and HOD :

b) Associate Professors/s :

c) Asst. Professors/s :

d) Registrars/Sr. Residents :

e) Jr. Residents

f) Non-teaching and Clerical Staff :

**D. TEACHING HOSPITAL**

* + - 1. **INPATIENT DEPARTMENT**

|  |  |
| --- | --- |
| **Inpatient Departments** | **Pediatrics** |
| * 1. Total beds |  |
| * 1. Number of Teaching Beds |  |
| * 1. Number of Units |  |
| * 1. Unit-wise staff composition with their Names, Qualifications and designation | Attach separate sheet |
| * 1. Annual indoor admissions |  |
| * 1. Average bed occupancy per day (% of teaching beds) |  |

* + - 1. **INTENSIVE CARE No. of beds Equipment available**

1. Pediatric Intensive Care Unit

b) Neonatal Intensive Care Unit

* + - 1. **MAJOR EQUIPMENT AVALIABLE IN THE DEPARTMENT:**
      2. **OUT-PATIENT DEPARTMENT:**
         1. Building – General layout
         2. Is outpatient service Department wise
         3. Arrangement for clinical instructions to students in Pediatrics
         4. Average Daily OPD Attendance

1. Old Patients

2. New Patients

3. Total

* + - 1. **CLINICS : Weekly frequency Are UG students posted**

**in these clinics**

1. Well Baby Clinic
2. Immunization Clinic
3. Child Guidance Clinic
4. Child Rehabilitation Clinic including

facilities for speech & occupational therapy

1. Any other clinic
2. **NEW BORN NURSERY:**

i) No. of beds :

1. Does it have facilities for temperature

and humidity control?

1. Staff posted
2. Medical :
3. Staff Nurses :
4. Equipment available

(v) Are the undergraduate students posted in delivery room?

If yes, who supervises their training for neonatal resuscitation?

1. Faculty of Obstetrics&Gynecology
2. Faculty of Pediatrics
3. Any other
4. **TEACHING AND TRAINING FACILITIES :**

### **In OPD**

1. Clinical demonstration room:
2. Number of rooms in the OPD for examining Patients by faculty members and Residents :
3. **In-door**
4. Bedside teaching
5. Clinical demonstration room/seminar room
6. **Teaching Programme:**
   * + 1. **Teaching Learning Methods**

|  |  |
| --- | --- |
|  | **No. held in past 1 year** |
| 1. Total Clinical posting |  |
| 1. Lectures |  |
| 1. Tutorials |  |
| 1. Demonstrations |  |
| 1. Seminars conducted |  |
| 1. Bed side teaching |  |
| 1. Practical |  |
| 1. Hours spent by a Student daily in the wards for clerkship. |  |
| 1. Average Number of students posted at a time for indoor/ OPD Postings. |  |
| 1. Do students write case histories in a prescribed book |  |
| 1. Is the clinical work done in the wards by the Students assessed Periodically? |  |
| 1. If yes to #11, how often and by whom? |  |
| 1. Total period of attendance in OPD by a student throughout clinical training. |  |
| 1. Is it done concurrently with the inpatients ward postings? |  |
| 1. Who gives them training to attend to emergencies? |  |
| 1. How is the outpatients teaching organized? |  |
| 1. Do students attend Clinico-pathological Conferences? |  |
| 1. If Yes, how many (average in a year) |  |
| 1. Any other activities? (specify) |  |

1. Any innovations in teaching/learning methods? If Yes, specify
   * + 1. **Methods of Assessment** :

(Teaching schedule to be given).

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes,provide details:

* + - 1. **Internship Training Programme**
         1. Period of posting in the department
         2. Method of assessment ofInternship (please attach aCopy of log book/assessment Sheet)

### Signature of Head of the Department Signature of Dean/Principal

**(SIF B-11)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**SURGERY**

**(INCLUDING GENERAL SURGERY, ORTHOPAEDICS, OTO-RHINO-LARYNGOLOGY, OPHTHALMOLOGY, RADIO-DIAGNOSIS, RADIOTHERAPY, ANAESTHESIOLOGY, PHYSICAL MEDICINE & REHABILITATION AND DENTISTRY**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

**Signature of the Dean/Principal Signature of the**

**(with seal) Head of the Department**

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill-in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficiencies pointed out in the last assessment/ To what extent rectified

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A1: Department of General Surgery**

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| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A2: Department of Orthopedics**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A3: Department of Ophthalmology**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A4: Department of Oto-Rhino-Laryngology**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A5: Department of Radio-diagnosis**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A6: Department of Radio-therapy**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A7: Department of Anesthesiology**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A8 : Department of Physical Medicine & Rehabilitation**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**A9: Department of Dentistry**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. LIST OF NON-TEACHING STAFF :**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Nomenclature | Names of staff members | | | |
| **General Surgery** | **Orthopedics** | **Oto-Rhino-Laryngology** | **Ophthalmology** |
| **Technical Assistant** |  |  |  |  |
| **Technician** |  |  |  |  |
| **Lab Attendant** |  |  |  |  |
| **Steno-typist** |  |  |  |  |
| **Record Clerk** |  |  |  |  |
| **Audiometry Technician** |  |  |  |  |
| **Speech therapist** |  |  |  |  |
| **Refractionist** |  |  |  |  |
| **Any other category** |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Nomenclature** | Names of staff members | | | | |
| **Radio-Diagnosis** | **Radio-Therapy** | **Anesthesiology.** | **Phy. Med. & Rehab.** | **Dentistry** |
| **Radiographic Technician** |  |  |  |  |  |
| **Stenographer** |  |  |  |  |  |
| **Steno-typist** |  |  |  |  |  |
| **Storekeeper** |  |  |  |  |  |
| **Record Clerk** |  |  |  |  |  |
| **Radiotherapy Technician** |  |  |  |  |  |
| **Physio-therapist** |  |  |  |  |  |
| **Occupational therapist** |  |  |  |  |  |
| **Speech Therapist** |  |  |  |  |  |
| **Prosthetic and orthodox Technician** |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Nomenclature** | Names of staff members | | | | |
| **Radio-Diagnosis** | **Radio-Therapy** | **Anaesthesiology** | **Phy. Med. & Rehab.** | **Dentistry** |
| **Clinical Psychologist** |  |  |  |  |  |
| **Medio-Social worker** |  |  |  |  |  |
| **Public Health Nurse/Rehabilitation Nurse** |  |  |  |  |  |
| **Vocational Counsellor** |  |  |  |  |  |
| **Multi-rehabilitation worker (MRW)/Technician/therapist** |  |  |  |  |  |
| **Dental Technicians** |  |  |  |  |  |
| **Tech. Asst.** |  |  |  |  |  |
| **Technicians** |  |  |  |  |  |
| **Any other category** |  |  |  |  |  |

**C. BUILDINGS: Gen Ortho Oto-Rhino Ophthal Radiodiagnosis**

**Surgery Laryngology**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(i) Clinical Demo Room

a) Number

b)Accommodation (of

each demo room)

i)Size

ii)Capacity

c)A-V equipment available

(ii)Departmental Library-cum-

Seminar Room:

* + - * 1. Is there a separate departmental library?

1. Accommodation

* Size
* Capacity

c) Number of Books :

d) List of Journals :

1. Research Laboratory

a) Size

b) Equipment

c) Are there any students taken for M.D/M.S.?

If so how many per year during the last three years?

1. Diploma
2. Degree

d) List of publications by the members of the

staff during the last 3 years?

e) Current Research areas

f) Do Undergraduate students in any way participate in them?

1. **OFFICE ACCOMMODATION Gen Ortho Oto-Rhino Ophthal Radiodiagnosis**

**Surgery Laryngology**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

a)Professor and HOD :

b)Associate Professors/s :

c)Asst. Professors/s :

d)Registrars/Sr. Residents :

e)Junior Residents :

e)Non-teaching & clerical staff:

1. **TEACHING HOSPITAL**
   * 1. **INPATIENT DEPARTMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Inpatient Departments** | **General Surgery** | **Orthopedics** | **Otorhinolaryngology** | **Ophthalmology** |
| * 1. Total beds |  |  |  |  |
| * 1. Number of Teaching Beds |  |  |  |  |
| * 1. No. of Units |  |  |  |  |
| * 1. Unit-wise staff composition with Names, Qualifications& designation | Attach separate sheet | Attach separate sheet | Attach separate sheet | Attach separate sheet |
| * 1. Annual indoor admissions |  |  |  |  |
| * 1. Average bed occupancy per day (% of teaching beds) |  |  |  |  |

* + 1. **INTENSIVE CARE**

Is there any Intensive Care UnitFor surgery and allied specialties:

If yes, please indicate a number ofBeds and equipment available for each specialty.

**Name of specialty No.of beds Equipment’s available**

* + 1. **MAJOR EQUIPMENT AVALIABLE IN THE DEPARTMENT: Names of equipment**

a) General Surgery

b) Orthopedics

c) Oto-Rhino-Laryngology

d) Ophthalmology

e) Radio-diagnosis

f) Radio-therapy

1. Anesthesiology
2. Physical Medicine &Rehabilitation

i) Dentistry

* + 1. **Outpatient Department :**

a) Building – General layout

b) Is out patient service department wise

c) Arrangement for clinical Instructions to

student in General Surgery & Allied specialties

d) Average Daily OPD Attendance **General Ortho. Oto-Rhino Ophth**

**Surgery Laryngology**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Old Patients

2. New Patients

3. Total

* + 1. **Teaching and training facilities:**

**A. In O.P.D.**

a) Clinical demonstration room:

b) Number of rooms in the OPD

for examining patients by faculty

members and residents.

**B. In-door**

a) Bedside teaching

b) Clinical demonstration room/

seminar room

1. **FACILITIES AVALIABLE IN OUT-PATIENT DEPARTMENT:**
2. **In Surgery and allied specialty**
3. Dressing room for men Yes / No
4. Dressing room for women Yes / No
5. Operation theatres for out patient surgery Yes / No
6. **In Orthopedics**
7. Plaster room Yes / No
8. Plaster cutting room Yes / No
9. Outpatient X-ray facilities Yes / No
10. **In Oto-Rhino-Laryngology**
11. Sound proof air-conditioned audiometry room Yes / No
12. ENG Laboratory Yes / No
13. Speech therapy facilities Yes / No
14. **In Ophthalmology**
15. Refraction room Yes / No
16. Dressing room Yes / No

**8.** **OPERATION THEATRE UNIT:**

(1) Operation theatres

(a) Number :

(b) Arrangement &Distribution :

(c) Equipment (including Anesthesia equipment)

(d) Facilities available in each O.T. unit

(i) Waiting room for patients Yes / No

(ii) Soiled Linen room Yes / No

(iii) Sterilization room Yes / No

(iv) Nurses duty room Yes / No

(v) Surgeons & Anesthetists room -

* For Males Yes / No
* For Females Yes / No

(vi) Assistants room Yes / No

(vii) Observation gallery for students Yes / No

(viii) Store room Yes / No

1. Washing room for surgeons and assistants Yes / No
2. Students washing and dressing room Yes / No

(2) Arrangement of Anesthesia

(a) Pre-anestheticcare Yes / No

(b) Post-anestheticcare Yes / No

(3) Pre-operative ward (no. of beds) :

1. Post-operative ward (no. of beds) :
2. Resuscitation facilities and special equipment :
3. If any super specialty exist;

Give details

(7) Number of surgeries performed during the last one year.

**Names of the department Major Minor**

1. General Surgery
2. Orthopedics
3. Oto-Rhino-Laryngology
4. Ophthalmology

**TEACHING PROGRAMME:**

* + - 1. **Teaching Learning Methods**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **No. Held in past 1 year** | | | | | | |
| **General Surgery** | **Ortho-pedics** | **Oto-rhino-laryngology** | **Ophthal-mology** | **Radiology** | **Anesthesia** | **Dentistry** |
| 1. Total Clinical posting |  |  |  |  |  |  |  |
| 1. Lectures |  |  |  |  |  |  |  |
| 1. Tutorials |  |  |  |  |  |  |  |
| 1. Demonstrations |  |  |  |  |  |  |  |
| 1. Seminars conducted |  |  |  |  |  |  |  |
| 1. Bed side teaching |  |  |  |  |  |  |  |
| 1. Practical |  |  |  |  |  |  |  |
| 1. Hours spent by a Student daily in the wards forclerkship. |  |  |  |  |  |  |  |
| 1. Average Number of students posted at a time for indoor/ OPD Postings. |  |  |  |  |  |  |  |
| 1. Do students write case histories in a prescribed book |  |  |  |  |  |  |  |
| 1. Is the clinical work done in the wards by the Students assessed Periodically? |  |  |  |  |  |  |  |
| 1. If yes to #11, how often and by whom? |  |  |  |  |  |  |  |
| 1. Total period of attendance in OPD by a student throughout clinical training. |  |  |  |  |  |  |  |
| **Activity** | **No. Held in past 1 year** | | | | | | |
| **General Surgery** | **Ortho-pedics** | **Oto-rhino-laryngology** | **Ophthal-mology** | **Radiology** | **Anesthesia** | **Dentistry** |
| 1. Is it done concurrently with the inpatients ward postings? |  |  |  |  |  |  |  |
| 1. Who gives them training to attend to emergencies? |  |  |  |  |  |  |  |
| 1. How is the outpatients teaching organized? |  |  |  |  |  |  |  |
| 1. Do students attend Clinico-pathological Conferences? |  |  |  |  |  |  |  |
| 1. If Yes, how many (average in a year) |  |  |  |  |  |  |  |
| 1. Any other activities? (specify) |  |  |  |  |  |  |  |

1. Any innovations in teaching/learning methods? If Yes, specify
   * + 1. Assessment Methods (Please provide details)

(Teaching schedule to be attached)

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

**Gen. Ortho. Oto- Opth. Surgery rhino**

* + - 1. Internship training programme
  1. Period of posting in the department
  2. Method of Assessment

(Please attach a copy of logbook/assessment sheet).

**Signature of Heads of the Department Signature of Dean/Principal**

General Surgery

Oto-Rhino-Laryngology

Ophthalmology

Radio-Diagnosis.

Radio-therapy

Anesthesiology

Physical Medicine & Rehabilitation

Dentistry

**(SIF B-12)**

**NATIONAL MEDICAL COMMISSION**

**STANDARD ASSESSMENT FORM**

**FORM – B**

On the

Facilities for teaching in the subject of

**OBSTETRICS AND GYNAECOLOGY**

For the Course of study leading up to

M.B.B.S.

**Name of Institution** ………..………..…….……..………..………………...………..

**Place** ………..………..………..………..………..………..………..………..………..

**Affiliated to the University of** ……………………………………………………….

**Name of the Head of the Department** …………..………………………………….

**Signature of the Dean/Principal Signature of the (with seal) Head of the department**

(This form shall be first filled in by the Principal/Dean of the college in collaboration with the Head of the Department and handed over to the Assessor, who shall examine the information already furnished & gather such additional information as may be necessary to fill-in the spaces provided for within)

1. Date of Assessment :

2. Names of Assessors :

3. Date of last Assessment :

4. Names of last Assessors :

Deficiencies pointed out in the last assessment/ To what extent rectified

**A. Teaching Staff:**In case this space is less a statement showing the following information may be attached in this format. (to be filled in by the Dean/Principal of the college).

**Department of Obstetrics and Gynecology**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **No.** | **Name and Medical Regn. No** | **Qualification with dates & where obtained** | | | Experience | | | | | | | |
|  | | | | | | **As Demonstrator/Tutor** | | | | **As Asst. Professor** | | | |
|  | | | Date | College | University | Instt. | From | To | **Total** | Instt. | From | To | **Total** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **Professor** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |  |  |  |  |

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|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post** | **Experience** | | | | | | | | **Total Teaching Experience**  **and Remarks if any** |
| **As Assoc. Professor/** | | | | **As Professor** | | | |
|  | Institution | From | To | **Total** | Institution | From | To | **Total** |
|  | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| **Professor** |  |  |  |  |  |  |  |  |  |
| **Assoc. Prof.** |  |  |  |  |  |  |  |  |  |
| **Asst. Prof.** |  |  |  |  |  |  |  |  |  |
| **Registrar/Sr Resident** |  |  |  |  |  |  |  |  |  |
| **Junior Resident** |  |  |  |  |  |  |  |  |  |
| **Any other Category** |  |  |  |  |  |  |  |  |  |

**B. LIST OF NON-TEACHING STAFF:**

|  |  |  |
| --- | --- | --- |
| **Sl.No** | **Nomenclature** | **Name(s) of staff members** |
| 1 | Antenatal Medical Officer-cum-Assistant Professor |  |
| 2 | Maternity and Child Welfare Officer-cum-Asst. Professor |  |
| 3 | Social Worker |  |
| 4 | Technical Assistant |  |
| 5 | Technician |  |
| 6 | Lab Attendants |  |
| 7 | Stenographer |  |
| 8 | Record Clerk |  |
| 9 | Store Keeper |  |
| 10 | Any other Category |  |

1. **BUILDINGS:**

**(i) ClinicalDemonstration Room:**

* + - * 1. Number
        2. Accommodation (of each demonstration room)

i) Size:

1. Capacity:
2. Audio-Visual equipment available.
3. **Departmental Library – cum- Seminar Room:**
4. Is there a separate departmental library?
5. Accommodation

i) Size :

ii) Capacity:

1. Number of books in Obstetrics & Gynecology and allied subjects
2. List of Journals:
3. **Research Laboratory**
4. Size
5. Equipment

c) Are there any students taken for M.S/Dip in OB-GYN?If so how many per year during the last three years?

1) Diploma

2) Degree

d) List of publications by the members of the staff in the preceding 3 years:

e) Current Research areas (statement may be furnished)

1. Do Undergraduate students in any way participate in them?

**(iv) OFFICE ACCOMMODATION**

a) Professor and HOD :

b) Associate Professors/s :

c) Asst. Professors/s :

d) Registrars/Sr. Residents :

e) Jr. Residents :

1. Non-teaching & Clerical staff:

**D. TEACHING HOSPITAL**

* + 1. **INPATIENT DEPARTMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **Inpatient Departments** | **Obstetrics** | **Gynecology** | **Postpartum** |
| * 1. Total beds |  |  |  |
| * 1. Number of Teaching Beds |  |  |  |
| * 1. Numberof Units |  |  |  |
| * 1. Unit-wise staff composition with their Names, Qualifications and designation | Attach separate sheet | Attach separate sheet | Attach separate sheet |
| * 1. Annual indoor admissions |  |  |  |
| * 1. Average bed occupancy per day (% of teaching beds) |  |  |  |

2. **INTENSIVE CARE**

* 1. Is there an Intensive Care Unit for Obstetrics & Gynecology: Yes / No
  2. If yes, please indicate number of beds and equipmentavailable:

**No. of beds Equipment available**

(Attach separate sheet if required)

1. **NEONATAL UNIT**
   1. Number of cots/beds:
   2. Facilities for temperature and humidity control: Yes / No.
   3. Staff posted
      1. Medical
      2. Non-medical
2. Equipment available

**4.** **MAJOR EQUIPMENT AVALIABLE IN THE DEPARTMENT:**

List names of equipment

**5.** **OUTPATIENT DEPARTMENT:**

a) Building – General layout

b) Is out patient service department wise

c) Arrangement for clinical Instructions to student in Obstetrics & Gynecology:

d) Average Daily OPD Attendance

1. Old Patients :

2. New Patients :

3. Total :

1. **TEACHING AND TRAINING FACILITIES:**
2. **In O.P.D.**
3. Clinical demonstration room :
4. Number of rooms in the OPD

for examining patients by the

faculty membersand residents. :

1. **In-door**
2. Bedside teaching
3. Clinical demonstration room/seminar room

**7.** **FACILITIES AVALIABLE IN OUT-PATIENT DEPARTMENT:**

1. Antenatal ClinicFrequency and run by whom
2. Family Welfare ClinicFrequency and run by whom
3. Postnatal Clinic frequency and run by whom
4. Sterility clinic frequency and run by whom
5. Cancer detection clinic and run by whom
6. Are medical students posted in these clinics?

**9.** **OPERATION THEATRE (WITH OBST&GYNAE. DEPT.)**

* 1. Number: ………..
  2. Size ……….. m2
  3. Equipment Yes / No
  4. Lighting arrangement Yes / No
  5. Air conditioning Yes / No
  6. Arrangements for students to watch Yes / No
  7. Anesthetic room Yes / No
  8. Preparation room Yes / No
  9. Recovery room Yes / No
  10. Post-operative wards Yes / No
  11. Resuscitation & blood transfusion services Yes / No
  12. Any other

**10. LABOURROOM:**

1. Clean Yes / No
2. Septic Yes / No
3. Number of beds in each
4. Arrangement of lights Yes / No
5. Arrangement for Sterilization Yes / No
6. Preparation room Yes / No
7. Waiting wards Yes / No
8. Anesthesia staff &facilities for anesthesia Yes / No
9. Newborn Baby room Yes / No
10. **POSTPARTUM UNIT**
11. Is there a postpartumunit attached to the department?

b) If yes, staff under the postpartum unit.

**Name andDesignation Qualifications.**

1. Medical
2. Non-Medical

c) Number of beds

1. **OPERATIONS &DELIVERIES IN THE PAST ONE YEAR:**

a) Gynecological Operations

Major :

Minor :

1. Total number of normalDeliveries :
2. Total number of Caesarian sections :
3. Antenatal cases seen in OPD :
4. Total number of sterilization’s

1) Tubectomies :

2) Medical Termination of Pregnancies (MTP) :

**E. TEACHING PROGRAMME :**

1. **Teaching Learning Methods**

|  |  |
| --- | --- |
| **Activity** | **No. held in past 1 year** |
| 1. Total Clinical posting |  |
| 1. Lectures |  |
| 1. Tutorials |  |
| 1. Demonstrations |  |
| 1. Seminars conducted |  |
| 1. Bed side teaching |  |
| 1. Practical |  |
| 1. Hours spent by a Student daily in wards for clerkship. |  |
| 1. Average Number of students posted in indoor/ OPD Postings. |  |
| 1. Do students write case histories in a prescribed book |  |
| 1. Is the clinical work done in the wards assessed Periodically? |  |
| 1. If yes to #11, how often and by whom? |  |
| 1. Total period of OPD attendance throughout clinical training. |  |
| 1. Is it done concurrently with inpatients ward postings? |  |
| 1. Who gives them training to attend to emergencies? |  |
| 1. How is the outpatients teaching organized? |  |
| 1. Do students attend Clinico-pathological Conferences? |  |
| 1. If Yes, how many (average in a year) |  |
| 1. Any other activities? (specify) |  |

1. Any innovations in teaching/learning methods? If Yes, specify
2. **Methods of Assessment** :

(Provide details)

(Teaching schedule to be given).

Do all teaching areas including laboratories in your department have live streaming capability? Yes/No

If not, which areas do not have live streaming capability? List the areas.

Are any of the teaching areas including Museums of your department shared with any other department/s? Yes/No

If yes, provide details:

1. **Internship Training Programme**
   * + - 1. Period of posting in the department
         2. Method of assessment ofInternship (Attach copy of log book book/assessment Sheet)

**Signature of Head of the Department Signature of Dean/Principal**