

**STANDARD ASSESSMENT FORM- B****(DEPARTMENTAL INFORMATION)  
CLINICAL HAEMATOLOGY**

1. *Kindly read the instructions mentioned in the Form 'A'.*
2. *Write N/A where it is Not Applicable. Write 'Not Available', if the facility is Not Available.*

**A. GENERAL:**

- a. Date of LoP when PG course was first Permitted: \_\_\_\_\_
- b. Number of years since start of PG course: \_\_\_\_\_
- c. Name of the Head of Department: \_\_\_\_\_
- d. Number of PG Admissions (Seats): \_\_\_\_\_
- e. Number of Increase of Admissions (Seats) applied for: \_\_\_\_\_
- f. Total number of Units: \_\_\_\_\_
- g. Number of beds in the Department: \_\_\_\_\_
- h. Total number of ICU beds/ High Dependency Unit (HDU) beds in the department: \_\_\_\_\_
- i. Number of Units with beds in each unit: (Specialty applicable):

Unit	Number of Beds	Unit	Number of beds
Unit-I		Unit-V	
Unit-II		Unit-VI	
Unit-III		Unit-VII	
Unit-IV		Unit-VIII	

- j. Details of PG inspections of the department in last five years:

Date of Inspection	Purpose of Inspection <i>(LoP for starting a course/permission for increase of seats/ Recognition of course/ Recognition of increased seats /Renewal of Recognition/Surprise /Random</i>	Type of Inspection <b>(Physical/ Virtual)</b>	Outcome <i>(LOP received/denied. Permission for increase of seats received/denied. Recognition of course done/denied. Recognition of increased seats done/denied /Renewal</i>	No of seats Increased	No of seats Decreased	Order issued on the basis of inspection <i>(Attach copy of all the order issued</i>

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	<i>Inspection/ Compliance Verification inspection/other)</i>		<i>of Recognition done/denied /other)</i>			<i>by NMC/M CI) as Annexu re</i>

k. Any other Course/observer ship (PDCC, PDF, DNB, M.Sc., PhD, FNB, etc.) permitted/ not permitted by MCI/NMC is being run by the department? If so, the details thereof:

Name of Qualification (course)	Permitted/not Permitted by MCI/NMC	Number of Seats

**B. INFRASTRUCTURE OF THE DEPARTMENT:**

**a. OPD**

No of rooms: \_\_\_\_\_

Area of each OPD room (add rows)

	Area in M <sup>2</sup>
<b>Room 1</b>	
<b>Room 2</b>	

Waiting area: \_\_\_\_\_ M<sup>2</sup>

Space and arrangements: **Adequate/ Not Adequate.**

If not adequate, give reasons/details/comments: \_\_\_\_\_

**b. Wards**

No. of wards: \_\_\_\_\_

Parameters	Details
Distance between two cots (in meter)	
Ventilation	Adequate/Not Adequate
Infrastructure and facilities	
Dressing and procedure room	

**c. Department office details:**

Department Office	
Department office	Available/not available

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Staff (Steno /Clerk)	Available/not available
Computer and related office equipment	Available/not available
Storage space for files	Available/not available

<b>Office Space for Teaching Faculty/residents</b>	
Faculty	Available/not available
Head of the Department	Available/not available
Professors	Available/not available
Associate Professors	Available/not available
Assistant Professor	Available/not available
Senior residents rest room	Available/not available
PG rest room	Available/not available

**d. Seminar room**

Space and facility: Adequate/ Not Adequate

Internet facility:

Audiovisual equipment details:

**e. List of Department specific laboratories with important Equipment:**

Name of Laboratory	Size in square meter	List of important equipment available with total numbers	Adequate/ Inadequate

**f. Library facility pertaining to the Department/Speciality (Combined Departmental and Central Library data):**

Particulars	Details
Number of Books	
Total books purchased in the last three years (attach list as Annexure	
Total Indian Journals available	
Total Foreign Journals available	

Internet Facility: Yes/No

Central Library Timing: \_\_\_\_\_

Central Reading Room Timing: \_\_\_\_\_

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**Journal details**

Name of Journal	Indian/foreign	Online/offline	Available up to

**g. Departmental Research:**

Research Projects Done in past 3 years.	
List of Research projects in progress.	

**h. Equipment**

Name of the Equipment	Available/Not available	Functional Status	Important specification in brief
Automated blood Cell counter			
Automated Coagulometer			
Centrifuge machine			
Deep freezer			
Electrophoresis unit			
ELISA Readers			
Spectrophotometer			
Co <sub>2</sub> incubator			
Fluorescence microscope			
PCR machine			
Centrifuge machine			
Oven			
Shaker			
Hot plate			
Biochemistry analyser			
Laminar air flow			

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**C. SERVICES:**

i. Intensive care service provided by the department:

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

Name of the Clinic	Days on which held	Timings	Average No. of cases attended	Name of Clinic In-charge
Haemoglobinopathy Clinic				
Malignant hematology Clinic				
Prenatal Diagnostic Clinic				
Hemophilia And Coagulation Disorders Clinic				
Bone marrow transplant clinic				

iii. Services provided by the Department.

service	Yes/No	If Yes – Weekly Workload (average of last year)
Haematology laboratory		
Bone marrow aspirations & biopsies		
Lumbar puncture		
Thalassemia Transfusion Centre		
Bone marrow transplant		
Bone Marrow Harvest		
Apheresis		
Extracorporeal Photopheresis		
Phototherapy (Puva)		
Cell Therapy Including Car-T Cell		
Rehabilitation		
Counselling		
Others		

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**D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF CLINICAL HAEMATOLOGY:**

<b>Parameters</b>	<b>On the day of inspection</b>	<b>Previous day data</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Total numbers of Out-Patients					
Out-Patients attendance (write <b>Average daily Out-Patients attendance</b> in column 4,5,6) *					
Total numbers of new Out-Patients					
New Out Patients attendance (write average in column 4,5,6)* for Average daily New Out-Patients attendance					
Total Admissions for Year					
Bed occupancy			X	X	X
Bed occupancy for the whole year above 75 % (prepare a data table)	X	X	Yes/ No	Yes/ No	Yes/ No
Bone marrow aspiration					
Lymph Node Biopsy					
PT/APTT					
Factor Assay					
X-rays per day (OPD + IPD) (write average of all working days in column 4,5,6)					
Ultrasonography per day (OPD + IPD) (write average of all working days in column 4,5,6)					

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CT scan per day (OPD + IPD) (write average of all working days in column 4,5,6)					
MRI per day (OPD + IPD) (average (write average of all working days in column 4,5,6)					
Cytopathology Workload per day (OPD + IPD) (write average of all working days in column 4,5,6)					
OPD Cytopathology Workload per day (write average of all working days in column 4,5,6)					
Haematology workload per day (OPD + IPD) (write average of all working days in column 4,5,6)					
OPD Haematology workload per day (write average of all working days in column 4,5,6)					
Biochemistry Workload per day (OPD + IPD) (write average of all working days in column 4,5,6)					
OPD Biochemistry Workload per day (write average of all working days in column 4,5,6)					
Microbiology Workload per day (OPD + IPD) (write average of all working days in column 4,5,6)					
OPD Microbiology Workload per day (write average of all working days in column 4,5,6)					
Total Deaths **					

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Total Blood Units Consumed including Components					
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\* **Average daily Out-Patients attendance** is calculated as below.

Total OPD patients of the department in the year divided by total OPD days of the department in a year

\*\**The details of deaths* sent by hospital to the Registrar of Births/Deaths

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**E. STAFF:**

**i. Unit-wise faculty and Senior Resident details:**

Unit no: \_\_\_\_\_

Sr. No.	Designation	Name	Joining date	Relieved/Retired/working	Relieving Date/Retirement Date	Attendance in days for the year/part of the year * with percentage of total working days** [days ( %)]	Phone No.	E-mail	Signature

\* - Year will be previous Calendar Year (from 1<sup>st</sup> January to 31<sup>st</sup> December)  
 \*\* - Those who have joined mid-way should count the percentage of the working days accordingly.

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- ii. **Total eligible faculties and Senior Residents (fulfilling the TEQ requirement, attendance requirement and other requirements prescribed by NMC from time-to-time) available in the department:**

Designation	Number	Name	Total number of Admission (Seats)	Adequate / Not Adequate for number of Admission
Professor				
Associate Professor				
Assistant Professor				
Senior Resident				

- iii. **P.G students presently studying in the Department:**

Name	Joining date	Phone No	E-mail

- iv. **PG students who completed their course in the last year:**

Name	Joining date	Relieving Date	Phone no	E-mail

## F. **ACADEMIC ACTIVITIES:**

S. No.	Details	Number in the last Year	Remarks Adequate/ Inadequate
1.	Clinico- Pathological conference		
2.	Clinical Seminars		
3.	Journal Clubs		
4.	Case presentations		
5.	Group discussions		
6.	Guest lectures		
7.	<i>Death Audit Meetings</i>		

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8.	Physician conference/ Continuing Medical Education (CME) organized.		
9.	Symposium		

**Note:** For seminars, Journal Clubs, Case presentations, Guest Lectures the details of dates, subjects, name & designations of teachers and attendance sheets to be maintained by the institution and to be produced on request by the Assessors/PGMEB.

**Publications from the department during the past 3 years:**

**G. EXAMINATION:**

**i. Periodic Evaluation methods (FORMATIVE ASSESSMENT):**  
(Details in the space below)

**ii. Detail of the Last Summative Examination:**

**a. List of External Examiners:**

Name	Designation	College/ Institute

**b. List of Internal Examiners:**

Name	Designation

**c. List of Students:**

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Name	Result (Pass/ Fail)

**d. Details of the Examination:** \_\_\_\_\_

Insert video clip (5 minutes) and photographs (ten).

**H. MISCELLANEOUS:**

**i. Details of data being submitted to government authorities, if any:**

**ii. Participation in National Programs.**  
(If yes, provide details)

**iii. Any Other Information**

**I. Please enumerate the deficiencies and write measures which are being taken to rectify those deficiencies:**

**Date:**

**Signature of Dean with Seal**

**Signature of HoD with Seal**

Signature of Dean

Signature of Assessor

**J.****REMARKS OF THE ASSESSOR**

1. Please **DO NOT** repeat information already provided elsewhere in this form.
2. Please **DO NOT** make any recommendation regarding grant of permission/recognition.
3. Please **PROVIDE DETAILS** of deficiencies and irregularities like fake/ dummy faculty, fake/dummy patients, fabrication/falsification of data of clinical material, etc. if any that you have noticed/came across, during the assessment. Please attach the table of list of the patients (IP no., diagnosis and comments) available on the day of the assessment/inspection.
4. Please comment on the infrastructure, variety of clinical material for the all-round training of the students.

Signature of Dean

Signature of Assessor