POST-GRADUATE MEDICAL EDUCATION BOARD
NATIONAL MEDICAL COMMISSION

APPLICATION FORM FOR STARTING A NEW QUALIFICATION (SPECIALITY)

Name of Institution: ______________________________________

Government/ Non-Government: ___________________

Standalone PG: YES/ NO

Name of the proposed new Qualification: ____________________________

Date of the report: __________

INSTRUCTIONS TO DEAN/ DIRECTOR/ PRINCIPAL & HEAD OF THE DEPARTMENT

1. Please read the form carefully before filling it up. Retrospective changes in data will not be allowed.
2. Do not edit or modify any part of the Form. Tampering with the format of this Form will render your submission invalid.
3. Write **N/A** where it is **not applicable**. Write **'Not Available'**, if the facility is **not available**.
4. Head of the Department and Dean will be responsible for filling all details and signing on all pages and at the end of the Form. Do not leave any section of the Form or part thereof unanswered. Incompletely filled Form shall be summarily rejected.
5. No abbreviations in names are acceptable.
6. Dean, Head of Department (HOD) and Faculty should be thoroughly well-versed with all Regulations and MSRs of NMC.
7. All Faculty and Senior Resident will fill up Declaration Form as per **Annexure** and it should be countersigned by HOD and Head of the institution. The original Declaration Form shall be preserved by the medical colleges/institutions.
8. Medical College shall maintain the Faculty and Senior Resident Declaration Form of all the faculty and Senior Residents who are relieved or retired during the reported year.
9. Add rows in a table as per requirement.
10. Any non-compliance/ wrong declaration will invite penalties as per NMC Regulations.
11. The working days will be calculated as per the following formula [365 – 52 (Sundays) – Holidays declared by the respective Government].
13. **'Parent speciality'** means speciality which was primarily covering the content of the syllabus and curriculum requirement of this proposed new speciality (qualification).
14. Attach following Annexures with application form – (i) **Standard Assessment Form-A**; (ii) **Standard Assessment Form-B of the Parent Speciality**.
15. Please deposit the requisite fee as per the Recognition of Medical Qualification Regulations, 2023.

Signature of Dean | Signature of Assessor

PART-I

Name of the proposed new Qualification: ___________________________________

1. Type of qualification: **Broad Speciality/Super Speciality/PDCC/PDF**

2. Name of the Speciality (Parent Speciality), which was primarily covering the content of the syllabus and curriculum requirement of this new speciality and the year of starting of the Parent speciality in your medical college/institution and total number of seats currently permitted: ____

3. What is the desirability/need of having this new speciality / qualification in the country in terms of -
   a. Requirement of the public health needs:
   b. Training requirement of students:

4. Kindly answer the following questions pertaining to establishment of academic set up and standards
   a. Do you have separate unit/ department of this proposed new qualification having exclusive infrastructure, faculties, and other staff/manpower? Yes/ No.

   b. If it is a Speciality requiring in-patient beds and outpatient department (OPD), do you have special beds allotted to this unit and have exclusive OPD for this proposed Speciality? Yes/No

   c. Are you running any fellowship/ training program of this new Speciality. Yes/No. If yes, give details.

   d. List of academic activity done under this new Speciality by the unit/ department.

   e. List of publications done in index journals as per NMC norms by faculty of this unit related to the work done in this new Speciality.

5. What measures would you suggest to prevent confusion in mind of public while seeking medical services?

6. What will be the overall impact of such recognition upon the public policy in India?

Signature of Dean   Signature of Assessor

PART – II

(INFORMATION OF PROPOSED NEW QUALIFICATION/ SPECILITY DEPARTMENT/UNIT)

1. Name of the proposed new Qualification: ________________________

A. GENERAL:

a. Total number of Units: __________

b. Number of beds in the Department: ____________

c. Number of Units with beds in each Unit:

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

d. 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 by MCI/NMC	Number of Admissions per year
	Yes/No	
	Yes/No	

B. INFRASTRUCTURE OF THE DEPARTMENT:

a. **OPD**
No of rooms: __________
Area of each OPD room (add rows)

	Area in M^2
Room 1	
Room 2	

Waiting area: ______ M^2

Space and arrangements: Adequate/ not adequate.

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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 /Procedure Room	

c. Department office details:

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

Office Space for Teaching Faculty/residents	
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: Available/Not Available

Audiovisual equipment details:

e. 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	

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Total Indian Journals available	
Total Foreign Journals available	

Internet Facility: Yes/No
Central Library Timing: ____________
Central Reading Room Timing: __________

Journal details:

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

f. Departmental Research Lab:

Space	
Equipment	
Research Projects completed in past 3 years	
List the Research Projects in progress in Research Lab	

g. Departmental Museum:

Space	
Total number of Specimens	
Total number of Chart/ Diagrams	

h. 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

i. Operation Theatres:

i. Do you fulfil the operational guidelines for Operation Theatres Complex prepared by the Ministry of Health and Family Welfare? **Yes/No**.
[Link: https://nhsrcindia.org/sites/default/files/Guidelines-on-OT.pdf]:
*(If **No**, then mention deficiencies and what measures are you taking to fulfill those deficiencies)*

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ii. Total number of operation theatre (tables) per week for each unit:

j. Equipment: List of important Equipment available in the Department

Name of the Equipment	Numbers Available	Functional Status	Important Specifications in brief

C. SERVICES PROVIDED BY DEPARTMENT:

i. Speciality clinics run by the Department with number of patients in each:

Name of the Clinic	Weekday/s	Timings	Number of cases (Avg)	Name of Clinic In-charge

ii. Services provided by the Department:

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Service / facility	Yes / No – Remarks if any

iii. ICU run by the Department:

Type	Available/ not Available	Number of total beds	Major Equipment list with important specifications	Bed occupancy on the day of inspection	Average daily bed occupancy for the last year

Any other intensive care service provided:
(List in the space provided below)

D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD:

Average daily workload	On the day of Assessment	Year 1	Year 2	Year 3 (Last year)
1	**2**	**3**	**4**	**5**
Total no of Out-Patients				
Out-Patients attendance for **Average daily Out-Patients attendance** *(write average in column 3, 4, 5)**				
Total no of new Out-Patients				
New Out Patients attendance *(write average in column 3, 4, 5)* * for Average daily New Out-Patients attendance				

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Average daily workload	**On the day of Assessment**	**Year 1**	**Year 2**	**Year 3 (Last year)**
1	**2**	**3**	**4**	**5**
Total Admissions for Year				
Bed occupancy		X	X	X
Bed occupancy for the whole year above 75% (Prepare a Data Table)	X	Yes/No	Yes/No	Yes/No
Total Major surgeries in the department				
Total Minor surgeries in the department				
X-rays per day (write average of all working days in column 3,4,5)				
Ultrasonography per day (write average of all working days in column 3,4,5)				
CT Scan per day (write average of all working days in column 3,4,5)				
MRI per day (write average of all working days in column 3,4,5)				
Histopathology Workload per day (write average of all working days in column 3,4,5)				
Cytopathology Workload per day (write average of all working days in column 3,4,5)				
Haematology workload per day (write average of all working days in column 3,4,5)				

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Average daily workload	On the day of Assessment	Year 1	Year 2	Year 3 (Last year)
1	**2**	**3**	**4**	**5**
Biochemistry Workload per day (write average of all working days in column 3,4,5)				
Microbiology Workload per day (write average of all working days in column 3,4,5)				
Total Deaths **				
Total Blood Units Consumed including Components				

*. **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

E. SURGERY WORKLOAD:

Name of the Surgery	On the day of Assessment	Year 1	Year 2	Year 3 (Last Year)

Signature of Dean　　　　　　　　　　Signature of Assessor

F. PROCEDURE WORKLOAD:

Procedures	On the day of Assessment	Year 3 (Last Year)

Signature of Dean

Signature of Assessor

G. 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 1st January to 31st December)
** - Those who have joined mid-way should count the percentage of the working days accordingly.

Signature of Dean

Signature of Assessor

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				

H. ACADEMIC ACTIVITIES:

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

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:

Signature of Dean　　　　　　　　　　　　　　　　Signature of Assessor

I. 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:**

Signature of Dean Signature of Assessor

J. Please enumerate the deficiencies and write measures are being taken to rectify those deficiencies:

Date: **Signature of Dean with Seal** **Signature of HoD with Seal**

Signature of Dean Signature of Assessor

K. 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