|  |  |
| --- | --- |
| C:\Users\NMCBM03\Desktop\Capture.JPG | **POST-GRADUATE MEDICAL EDUCATION BOARD****NATIONAL MEDICAL COMMISSION** |

**STANDARD ASSESSMENT FORM-A**

 (Institutional Information Common for **all PG Specialities**)

**INSTITUTIONAL INFORMATION**

Name of Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Government/ Non-Government: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Standalone PG: **Yes/ No**

Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of the Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. This Standard Assessment Form is meant for the purpose of giving Annual Disclosure Report (**Annual Self-Declaration)** by Medical Colleges/Institutions as required under **Section 4** of MSMER-2023 regulation and for the Assessment/Inspection of a medical college/an institution by the Assessor. It will be in **Three Parts**:

i. **Form-A** is for the Institutional Information and is common for all PG Specialities.

ii. **Form-B** is for Speciality specific information (**Broad**/**Super Speciality**).

iii. Faculty, Senior Resident and Post-Graduate Students Declaration Forms.

1. These Forms will be updated/modified from time to time. Please download it afresh at the time of any application/submission.
2. For the purpose of Annual Disclosure Report (**Annual Self-Declaration),** the Data of previous year (1st January to 31st December) will be considered.
3. Medical college/institution will fill up all the details/data. The Assessor will verify availability and functional status of major infrastructure and major equipment of the institution mentioned in **Form-A** and may verify the relevant workload data furnished by the medical college/institution as per the requirement. Assessor will verify in detail all the items mentioned in **Form-B** (Department Specific form).
4. The original copy of the Annual Self-Declaration Form shall be preserved by the medical colleges. The PDF copy of SAF will be sent by e-mail.
5. Please read the FORM carefully before filling it up. Retrospective changes in Data will not be allowed.
6. Do NOT edit or modify any part of the Form. Tampering with the format of this Form will render your submission invalid.
7. Write **N/A** where it is **not applicable**. Write **‘Not Available’**, if the facility is **not available**.
8. Head of the Department and Dean will be responsible for filling all columns 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 up Form shall be summarily rejected.
9. Dean, Head of Department (HoD) and Faculty should be thoroughly well-versed with all Regulations and MSRs of NMC.
10. All Faculty, Senior Residents and Post-Graduate students will fill up the **respective Declaration Forms.** It should be countersigned by HoD and Head of the institution. The original Declaration Form shall be preserved by the medical colleges/institutions.
11. Medical College shall maintain the **Declaration Forms** who are relieved or retired during the reported year.
12. Add rows in a Table as per requirement.
13. Non-compliance/wrong declaration or fake documents will invite penalties as per NMC regulations.
14. The working days will be calculated as per the following formula [365 – 52 (Sundays) –Holidays declared by the respective Government/medical college]. The dates of the Holidays to be provided by the medical college/institution as Annexure.
15. Annual detail of all clinical workload/ investigations will be provided as per the **Data** **Table** as and when asked for. Template of the Data Table is at end of this document.

**A. GENERAL INFORMATION OF MEDICAL COLLEGE/ INSTITUTION**

1. Name of Medical College/Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. College Type: Government/ Non-Government: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Stand-alone PG: **Yes/No**

4. LOP date of establishment of undergraduate college: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Dates of the Holidays of last year. **Attach file as Annexure.**

6. Total working days of last year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. College Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College City/Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pin Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. College Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. College E-mail ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. College Landline No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. College Mobile/Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. College Competent Authority: **Dean/ Director/ Principal**

13. College Competent Authority Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. College Competent Authority E-mail ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. College Competent Authority Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. College Competent Authority Landline No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Name and Address of Affiliated University: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Name and address of the Vice-Chancellor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. Landline No./Mobile No of the Vice-Chancellor.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. E-mail address of the Vice-Chancellor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. DETAIL OF UNDERGRADUATE MEDICAL COLLEGE/INSTITUTE:**

 Total number of UG seats: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Total hospital beds of all Departments required for UG College: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Parameter** | **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3** **(Last Year)** |
| **(1)** | **(2)** | **(3)** | **(4)** | **(5)** |
| Total OPD patients of alldepartments required for UG college *(Write the average of all the OPD days in a year in column 3, 4, 5)* |  |  |  |  |
| Bed Occupancy of all the required In-patient beds for UG College.*(Write average of all days in a year in column 3, 4, 5)*  |  |  |  |  |

**C. LIST OF ALL BROAD SPECIALITY AND SUPER SPECIALITY DEPARTMENTS EXISTING IN THE INSTITUTION WITH BASIC DETAILS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Department** | **Total Beds** | **Total No. of Units** | **Total No. of Admissions per year** | **Year of Starting the Course** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**D. COMMON INFRASTRUCTURE:**

**I. General:**

|  |  |  |
| --- | --- | --- |
| **Parameters** | **Availability** | **Adequate/ Not Adequate** |
| Central supply of Oxygen | **Yes/No** |  |
| Central Suction | **Yes/No** |  |
| Central Sterilization Department | **Yes/No** |  |
| Laundry | **Yes/No** |  |
| Kitchen | **Yes/No** |  |
| Generator facility | **Yes/No** |  |
| Bio-waste disposal | **Yes/No** |  |
| Computerized Medical Record Section | **Yes/No** |  |
| Which ICD classification being used | **ICD10/ICD11** |  |

**II. Out-Patient Department:**

 Space and arrangements : Adequate/Not Adequate

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **Parameter** | **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3 (Last Year)** |
| **(1)** | **(2)** | **(3)** | **(4)** | **(5)** |
| **Total OPD Patients of all the Departments in the hospital** ***(****Write the average of all the OPD days in a year in column 3, 4, 5)* |  |  |  |  |

**III. Blood Bank:**

 License valid till date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Blood component facility: **Available/Not Available**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **Parameter** | **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3****(Last Year)** |
| **(1)** | **(2)** | **(3)** | **(4)** | **(5)** |
| Blood Units including Components issued  |  |  |  |  |
| Blood Units including Components utilized in the hospital *(write average of all days in column 3,4,5)* |  |  |  |  |
| Average number of units utilized daily by the various Specialities*(Attach* ***Annexure)*** |  |  |  |  |
| Blood units collected  |  |  |  |  |
| Total Number of Cross matchings  |  |  |  |  |
| Number of units stored *(write average of all days in column 3,4,5)* |  |  |  |  |
| Number of Units available on Assessment Day |  | **X** | **X** | **X** |

**IV.** **Emergency Department/ Casualty Services**

Number of Beds (***Exclude beds in the Triage area): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

a. **Equipment:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Equipment** | **Numbers Available** | **Functional** **Status** | **Important Specifications in brief** |
| Ventilators |  |  |  |
| Defibrillators |  |  |  |
| Fully equipped disaster trolleys |  |  |  |
| Multipara monitors  |  |  |  |
| Dedicated portable x-ray machine available: |  |  |  |
| Number of Ambulances  |  |  |  |
| Ultrasonography with color Doppler and curvilinear probe, Linear probe, and Phased array probe(cardiac) |  |  |  |

 b. **Specific Clinical/ Investigative Workload of the Emergency Department:**

| **Particulars** | **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3****(Last Year)** |
| --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** |
| Number of patients attended (in the green zone/ OPD of the Emergency Department) for OPD workload. *(Write average daily attendance in columns 3, 4 and 5\*)* |  |  |  |  |
| Admissions (number of patients admitted in Red and Yellow Zones).*(Write average daily admission in columns 3, 4 and 5\*)* |  |  |  |  |
| Total number of patients admitted in the hospital through EM Deptt. |  |  |  |  |
| Bed occupancy for Percentage of Bed Occupancy  |  | X | X | X |
| Bed occupancy for the whole year above 75% (Prepare a Data Table) | X | Yes/No | Yes/No | Yes/No |
| Number of Major surgeries for patients attending EM#  |  |  |  |  |
| Number of Minor Surgery/Procedures in EM **@** |  |  |  |  |
| Details of the Procedures *(Give the details in the* ***Table*** *given below)* |  |  |  |  |
| Consumption of blood units for EM patients *(Write average of all 365 days in column 3,4,5)* |  |  |  |  |
| X-rays per day for EM patients *(Write average of all 365 days in column 3,4,5)* |  |  |  |  |
| Ultrasonography per day for EM patients *(Write average of all 365 days in column 3,4,5)* |  |  |  |  |
| CT scans per day for EM patients*(Write average of all 365 days in column 3,4,5)* |  |  |  |  |
| MRI scans per day for EM patients*(Write average of all 365 days in column 3,4,5)* |  |  |  |  |
| OPD Haematology workload per day for EM patients*(Write average of all 365 days in column 3,4,5)* |  |  |  |  |
| OPD Biochemistry workload per day for EM patients*(Write average of all 365 days in column 3,4,5)* |  |  |  |  |
| OPD Microbiology workload per day for EM patients*(Write average of all 365 days in column 3,4,5)* |  |  |  |  |
| ABG per day for EM patients*(Write average of all 365 days in column 3,4,5)* |  |  |  |  |
| Cardiac biomarkers per day (average) for EM patients |  |  |  |  |
| Total deaths in the EM Department |  |  |  |  |

\* Average daily attendance is calculated as below.

 *Total patients attending EM in the year divided by total number of days in a year*

# Total number of major surgeries of patients shifted to Hospital/Operating Room directly from ED or are operated in the ED Operation Theatre.

@ Minor Operation can be those that are done in the Procedure Room /Minor Operation Room inside the ED. These may include wound wash/debridement in the ED, wound suturing or removal, K-wiring, dislocation reduction, etc.

**Details of Procedures**

|  |  |  |
| --- | --- | --- |
| **Procedures** | **On the day of Assessment** |  **(Last Year)** |
| Central Line placement |  |  |
| Non-invasive ventilations |  |  |
| Pleural Tapping/Chest tube insertion |  |  |
| Pericardiocentesis |  |  |
| Cardioversion/Defibrillation |  |  |
| Incision and Drainage of abscess |  |  |
| Endotracheal Intubation with direct laryngoscopy |  |  |
| Major trauma primary care like splinting/dressing |  |  |
| Endotracheal intubation with video laryngoscopy |  |  |
| Tracheostomy |  |  |
| Ultrasonography |  |  |
| Transcutaneous Pacing |  |  |
| Regional Block |  |  |

**V.** **Intensive Care Facility:**

 Total intensive care unit beds in hospital: \_\_\_\_\_\_\_\_

 Total andhigh dependency beds in hospital: \_\_\_\_\_\_\_\_

TotalPost-operative/ Post Anaesthesia care unit beds in hospital:\_\_\_\_\_\_\_\_\_

 **Intensive care facilities**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type** | **Managed by which Department** | **Number of total beds** | **List of Major Equipment and their Numbers** | **Bed occupancy on the day of Assessment** | **Average bed occupancy for the last year** |
| Medical ICU- MICU  |  |  |  |  |  |
| Surgical ICU – SICU |  |  |  |  |  |
| Neonatal ICU- NICU  |  |  |  |  |  |
| Paediatrics ICU- PICU  |  |  |  |  |  |
| Intensive Coronary Care Unit – ICCU  |  |  |  |  |  |
| Critical care unit-CCU  |  |  |  |  |  |
| Any other ICU (add rows) |  |  |  |  |  |
|  |  |  |  |  |  |

**VI.** **Dialysis:**

a. Number of Beds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Number of Hemodialysis Machines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **On the day of assessment** | **Year 1** | **Year 2** | **Year 3** **(last year)** |
| Total Hemodialysis  |  |  |  |  |
| Total Peritoneal Dialysis  |  |  |  |  |

**VII.** **Radiology Department:**

 a. **Equipment:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sl.****No.** | **Name of the Equipment** | **Numbers Available** | **Functional Status** | **Important Specifications in brief** |
|  | X-Ray Machines- Statici.ii.iii. |  |  |  |
|  | X-Ray Machines- Portablei.ii.iii. |  |  |  |
|  | X-Ray Machines- TV/Imaging facility |  |  |  |
|  | CT Scan (Mention slices, year of manufacturing with other specifications)i.ii. |  |  |  |
|  | MRI (Mention Tesla, year of manufacture with other specifications) |  |  |  |
|  | USG – Grey Scale (mention probes available with each machine)i.ii.iii. |  |  |  |
|  | USG – Colour Doppler (mention probes available with each machine)i.ii.iii. |  |  |  |
|  | Mammography |  |  |  |
|  | DSA |  |  |  |
|  | Any other equipment (add rows) |  |  |  |

b. **Clinical workload of the Radio-diagnosis Department:**

| **Parameter** | **On the day of assessment** | **Year 1** | **Year 2** | **Year 3** **(Last Year)** |
| --- | --- | --- | --- | --- |
| **(1)** | **(2)** | **(3)** | **(4)** | **(5)** |
| **Total Plain X-rays (write average of all working days in a year in column 3, 4, 5)** |  |  |  |  |
| IVP |  |  |  |  |
| Barium Swallow |  |  |  |  |
| Barium Upper GI studies |  |  |  |  |
| Barium Meal Follow through |  |  |  |  |
| *Barium Enema* |  |  |  |  |
| *HSG* |  |  |  |  |
| *Silography* |  |  |  |  |
| Urethrogram  |  |  |  |  |
| MCUG  |  |  |  |  |
| Fistulography/Sinography |  |  |  |  |
| Total Number of Ultrasonography |  |  |  |  |
| Number of Ultrasonography*(write average of all working days in a year in column 3, 4, 5)* |  |  |  |  |
| Doppler studies for abdominal vessels and scrotal conditions |  |  |  |  |
| Doppler study for peripheral vessels |  |  |  |  |
| Doppler study for carotid vessels |  |  |  |  |
| Other Doppler studies |  |  |  |  |
| USG Guided procedures-FNAC/ Biopsy |  |  |  |  |
| USG Guided procedures –aspiration/intervention  |  |  |  |  |
| Total CT scan  |  |  |  |  |
| **Total CT scan per day***(write average of all working days in a year in column 3, 4, 5)* |  |  |  |  |
| Number of  plain CT Scans *(without contrast)* |  |  |  |  |
| Number of  plain CT Scans Brain |  |  |  |  |
| Number of  plain CT Scans Abdomen |  |  |  |  |
| Number of  plain CT Scans Head and Neck |  |  |  |  |
| Number of CT contrast Enterography |  |  |  |  |
| Number of CT contrast Urography |  |  |  |  |
| Number of CT contrast Enema |  |  |  |  |
| CT guided procedures like FNAC/BIOPSY |  |  |  |  |
| Total MRI  |  |  |  |  |
| **Total MRI per day**(write average of all working days in a year in column 3, 4, 5) |  |  |  |  |
| Number of plain MRI (without contrast) |  |  |  |  |
| Number of plain MRI Brain |  |  |  |  |
| Number of plain MRI for spine |  |  |  |  |
| Number of MRI with contrast |  |  |  |  |
| Number of MR Urography |  |  |  |  |
| Number of MR Cholangiopancreatography |  |  |  |  |
| Mammography |  |  |  |  |
| Angiography (Conventional) |  |  |  |  |
| Angiography (DSA) |  |  |  |  |
| Any others (Please add rows) |  |  |  |  |

**VIII. Pathology Department**

1. **General Information:**

|  |  |
| --- | --- |
| Spacing and Organization of Laboratories: | Adequate / Inadequate |
| Laboratory Management Information System: | Available / Not Available |
| Internal Quality Assurance Practiced: | Yes/No |
| External Quality Assurance Services Practiced:If yes, details of EQAS  | Yes/No |
| Lab Accredited:If Yes Give Details | Yes/No |

b. **Equipment:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Equipment** | **Numbers Available** | **Functional** **Status** | **Important Specifications in brief** |
| Binocular Microscopes  |  |  |  |
| Penta head Microscope  |  |  |  |
| Binocular Research Microscope with photography facility |  |  |  |
| Automated Tissue Processor |  |  |  |
| Microtome  |  |  |  |
| Cryostat for Frozen Sections |  |  |  |
| Microwave for IHC |  |  |  |
| Cell Counter |  |  |  |
| HPLC Machine (Hb variants) |  |  |  |
| Centrifuge / Cytospin |  |  |  |
| PT and Aptt Automated Analyzer/Coagulometer |  |  |  |
| Flowcytometry for Hematology |  |  |  |
| IHC equipment |  |  |  |
| Any other equipment (Add rows) |  |  |  |

c. **Details of different sections in the Department of Pathology:**

|  |  |  |
| --- | --- | --- |
| **Section** | **Area (M2)** | **Equipment available** |
| Histopathology |  |  |
| Cytology / Cytopathology |  |  |
| Hematology |  |  |
| Fluid section |  |  |
| Autopsy/ Morbid Anatomy |  |  |
| Other |  |  |

 d. **Clinical workload of the Pathology Department**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **Nature of Specimens** | **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3** **(Last Year)** |
| **(1)** | **(2)** | **(3)** | **(4)** | **(5)** |
| **Total number of histopathology investigations [(Total specimens (Organ/Part/Tissue)] for histopathology received and reported \***  |  |  |  |  |
|  Frozen sections |  |  |  |  |
| Special stains (give details below in brief) |  |  |  |  |
| Immunohistochemistry (mention below if outsourced)  |  |  |  |  |
| **Total Hematology Specimen received and tested** |  |  |  |  |
| **Total Cytopathology Specimen received and reported (Cytopathology workload)** |  |  |  |  |
| Fluid Cytology |  |  |  |  |
| Exfoliative Cytology |  |  |  |  |
| FNAC (Direct) |  |  |  |  |
| FNAC (CT guided) |  |  |  |  |
| FNAC (USG guided) |  |  |  |  |
| PBF |  |  |  |  |
| Bone marrow  |  |  |  |  |

e. **Histopathology**

 **Types of histopathological reports by the Department of Pathology:**

|  |
| --- |
| **Nature of Disease Reported** |
| **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3** **(Last year)** |
| Tuberculosis |  |  |  |  |
| Other infections/Inflammations |  |  |  |  |
| Benign/Non Neoplastic\* |  |  |  |  |
| Malignancies |  |  |  |  |
| Others (specify) |  |  |  |  |

**Note: \* Tuberculosis and Other infections/inflammations to be excluded here.**

f. **Hematology:**

* 1. Total Hematology samples received and tested: \_\_\_\_\_\_\_\_
	2. **Number of Investigations:**

|  |  |
| --- | --- |
| **Name of test** | **Total Numbers** |
| **Number on day of Assessment** | **Year 1** | **Year 2** | **Year 3****(Last Year)** |
| CBC |  |  |  |  |
| ESR  |  |  |  |  |
| Reticulocyte Count  |  |  |  |  |
| Absolute Eosinophil Count |  |  |  |  |
| Bone Marrow Aspiration |  |  |  |  |
| Bone Marrow Biopsy |  |  |  |  |
| PT, Aptt, TT  |  |  |  |  |

* 1. **Facilities for the work up of the following (Name of investigation & numbers per year):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of the Test** | **Number on day of Assessment** | **Year 1** | **Year 2** | **Year 3****(Last Year)** |
| Coagulation Disorders |  |  |  |  |
| Leukemia  |  |  |  |  |
| Nutritional Anemias |  |  |  |  |
| Hemolytic Anemias |  |  |  |  |

g. **Body Fluids (Clinical Pathology)**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of the Test** | **Number on Day of Assessment** | **Year 1** | **Year 2** | **Year 3****(Last Year)** |
| Urine: Routine |  |  |  |  |
| Urine Special: |  |  |  |  |
| Semen: Routine |  |  |  |  |
| Semen: Special |  |  |  |  |
| CSF |  |  |  |  |
| Sputum: |  |  |  |  |
| Other body fluids: |  |  |  |  |

**IX. Biochemistry Department**

1. **General Information:**

|  |  |
| --- | --- |
| Spacing and Organization of Laboratories: | Adequate / Inadequate |
| Laboratory Management Information System: | Available / Not Available |
| Internal Quality Assurance Practiced: | Yes/No |
| External Quality Assurance Services Practiced:If yes, details of EQAS  | Yes/No |
| Lab Accredited:If Yes Give Details | Yes/No |

**b. List of Department specific laboratories (e.g., undergraduate laboratory, postgraduate laboratory etc.) with important Equipment (if applicable):**

|  |  |  |
| --- | --- | --- |
| Laboratory | Equipment | Functional Status |
| UG Laboratory | As Per UGMSR2023 |  |
| PG Laboratory | 1. Electrophoresis
2. Chromatography
3. Spectrophotometer
4. Semi / Auto Analyzer
5. Electrolyte Analyzer
6. ELISA
 |  |
| Clinical Chemistry Laboratory in Hospital | 1. Semi Auto Analyzer
2. Fully Auto Analyzer
 |  |
| Immunochemistry  | 1. Immunochemistry Analyzer
2. CLIA
 |  |

**c. Clinical material and investigative workload of the Department of Biochemistry:**

**No. of samples received: \_\_\_\_\_\_\_\_\_\_**

**No. of Tests Done: ----------------------**

1. **Clinical chemistry Investigations:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Investigations** | **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3****(Last Year)** | **Daily Average for the Last Year** |
| Glucose |  |  |  |  |  |
| Urea |  |  |  |  |  |
| Creatinine |  |  |  |  |  |
| Serum bilirubin |  |  |  |  |  |
| Serum proteins |  |  |  |  |  |
| Electrolytes |  |  |  |  |  |
| Lipid profile |  |  |  |  |  |
| Calcium |  |  |  |  |  |
| Magnesium |  |  |  |  |  |
| Phosphorus |  |  |  |  |  |
| Uric acid |  |  |  |  |  |
| Urine analysis |  |  |  |  |  |
| Pleural fluid |  |  |  |  |  |
| CSF |  |  |  |  |  |
| Peritoneal Fluid |  |  |  |  |  |
| Any other |  |  |  |  |  |

**ii. Special investigations including enzymes, chemiluminescence and immunochemistry**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Investigations** | **On the day of assessment** | **Year 1** | **Year 2** | **Year 3** | **Daily Average for the last year** |
| Serum Amylase |  |  |  |  |  |
| Serum Lipase |  |  |  |  |  |
| Serum AST |  |  |  |  |  |
| Serum ALT |  |  |  |  |  |
| Serum ALP |  |  |  |  |  |
| Others |  |  |  |  |  |
| Hormonal Assays |  |  |  |  |  |
| Thyroid Hormones |  |  |  |  |  |
| Steroid Hormones |  |  |  |  |  |
| Sex Hormones |  |  |  |  |  |
| Other  |  |  |  |  |  |
| Vitamins Assay |  |  |  |  |  |
| Iron Profile |  |  |  |  |  |
| HbA1C |  |  |  |  |  |
| Ferritin |  |  |  |  |  |
| CRP |  |  |  |  |  |
| Tumor markers |  |  |  |  |  |
| Immunoglobulin Assays |  |  |  |  |  |
| Troponins |  |  |  |  |  |
| Others |  |  |  |  |  |
|  |  |  |  |  |  |

**X. Microbiology Department**

1. **General Information:**

|  |  |
| --- | --- |
| Spacing and Organization of Laboratories: | Adequate / Inadequate |
| Laboratory Management Information System: | Available / Not Available |
| Internal Quality Assurance Practiced: | Yes/No |
| External Quality Assurance Services Practiced:If yes, details of EQAS  | Yes/No |
| Lab Accredited:If Yes Give Details | Yes/No |

**b.** **Equipment:**

| **Name of the Equipment** | **Numbers Available**  | **Functional Status** | **Important Specifications in brief** |
| --- | --- | --- | --- |
| Binocular Microscopes  |  |  |  |
| Fluorescence Microscope |  |  |  |
| Inverted Microscope |  |  |  |
| Multi-header Microscope  |  |  |  |
| BOD Incubator |  |  |  |
| Bacterial Incubator |  |  |  |
| Hot Air Oven |  |  |  |
| Autoclave |  |  |  |
| Centrifuge |  |  |  |
| Anoxomat / McIntosh Fildes Jar |  |  |  |
| pH Meter |  |  |  |
| Electronic Weighing balance |  |  |  |
| Candle Jar |  |  |  |
| VDRL Shaker/ Rotator |  |  |  |
| ELISA Washer |  |  |  |
| ELISA Reader |  |  |  |
| LCD screens |  |  |  |
| Deep Freezer -200 |  |  |  |
| C Deep Freezer -800 |  |  |  |
| Laminar Flow Horizontal |  |  |  |
| Laminar Flow Vertical  |  |  |  |
| Biosafety Cabinet BSL2 |  |  |  |
| Digital Water Bath |  |  |  |
| Automated Blood Culture  |  |  |  |
| RT (Real Time) - PCR |  |  |  |
| Conventional PCR |  |  |  |
| GeneXpert |  |  |  |
| CLIA (Chemiluminescence-Immunoassay) |  |  |  |
| Any other equipment |  |  |  |

**c. Total number of Laboratories in the Department**:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Laboratory** | **Available****(Yes/ No)** | **General Facility***(Adequate/ Not Adequate. If not adequate, mention the deficiencies)* | **List of Essential equipment** |
| Bacteriology |  |  |  |
| Serology/ Immunology |  |  |  |
| Virology |  |  |  |
| Mycology |  |  |  |
| Parasitology |  |  |  |
| Mycobacteriology |  |  |  |
| STI Lab |  |  |  |
| Anaerobic |  |  |  |
| Media Room |  |  |  |
| Hospital Infection Control Testing Facility & Record keeping |  |  |  |
| ICTCDOTS  |  |  |  |

**d. Year-wise workload (past 3 years) for the entire hospital:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Particulars** | **On the day of assessment** | **Year 1** | **Year 2** | **Year 3****(last year)** |
| Bacteriology |  |  |  |  |
| Serology/ Immunology |  |  |  |  |
| Mycology |  |  |  |  |
| Parasitology |  |  |  |  |
| Virology |  |  |  |  |
| Molecular tests |  |  |  |  |
| Any others |  |  |  |  |

1. **Obstetrics and Gynecology Department**

**a.** **Infrastructure**

|  |  |
| --- | --- |
| 1. Total beds in Department
 |  |
| 1. Total operation theatres in the Department.
 |  |
| 1. Number of delivery tables
 |  |
| 1. No of beds in Eclampsia room with Multipara monitors, CTG and infusion pumps on each bed
 |  |

 **b. Equipment:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Equipment** | **Numbers Available** | **Functional Status** | **Important Specifications in brief** |
| Multiparameter Monitors  |  |  |  |
| Pulse Oxymeters |  |  |  |
| Infusion pump |  |  |  |
| CTG Machines |  |  |  |
| No of USG machines with Doppler facility and TV probe and convex probe– *(Should have minimum 2 machines)* |  |  |  |

**c.** **Workload**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Deliveries: (Total)** | **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3 (Last year)** |
| Normal (Vaginal) |  |  |  |  |
| Operative (Vaginal) |  |  |  |  |
| Operative (CAESAREAN) |  |  |  |  |
| **Deliveries including LSCS per week****(average of all weeks of the year)** | **X** |  |  |  |

**XII. Operation Theatre**:

 a. Total number of Operation Theatres with anesthesia facilities in whole hospital: \_\_\_\_\_\_\_\_\_\_

 b. Do you fulfil the operational guidelines for Operation Theatres Complex prepared by the Ministry of Health and Family Welfare? [Link: <https://nhsrcindia.org/sites/default/files/Guidelines-on-OT.pdf> ]: **Yes/No**.

If No then mention deficiencies and what measures are you taking to fulfill those deficiencies. (**Annexure**)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Particulars** | **On the day of Assessment** | **Year 1** | **Year 2** | **Year 3 (Last year)** |
| Total number of Major surgeries performed in all disciplines of the institute of entire hospital  |  |  |  |  |
| Total number of Minor operations of entire hospital of all departments) |  |  |  |  |

c. **List of Common Major Equipment in Operation Theatres:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Equipment**  | **Numbers Available** | **Functional Status** | **Important Specifications in Brief** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**XIII. Facilities for PG Students:**

**a. Separate Rest Room/Duty room for Male and Female students: Available/Not Available**

 **b. Hostel Accommodation for PG students*:***

|  |  |
| --- | --- |
|  **List** | **No. of Rooms available with attached Bath** |
| **S.No.** | **Details** | **Number** | **Boys** | **Girls** |
| **i.**  | **Total PG seats (Broad Speciality + Super Speciality):** |  |  |  |
| **ii.** | **Total required Senior Residents for Broad Speciality:** |  |

**Option of installation of air conditioner available: Yes/No**

 **c. Recreational Facilities:**

|  |  |  |
| --- | --- | --- |
| **Details** | **Available/ Not Available** | **Used regularly/not used** |
| **Playground with outdoor sports facility like cricket, football, basketball etc.** |  |  |
| **Gymnasium with indoor sports facilities like table tennis, badminton etc.** |  |  |

d. **Stipend paid to the PG students, Year-Wise:**

|  |  |  |
| --- | --- | --- |
| **Year** | **Stipend paid in Govt. Colleges by State Govt.** | **Stipend paid by the Institution\*** |
| 1st Year |  |  |
| 2nd Year |  |  |
| 3rd Year |  |  |

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

 **e. Anti-Ragging Committee Members (attach file as Annexure):**

 **f. Number of Anti-Ragging Committee Meetings held in the year:**

 **g. Whether Annual Report pertaining to Anti-Ragging Regulation Submitted: Yes/No**

 **XIV. Medical Record Section**

1. Organization of the Medical Record Section:
2. Staff:
3. Details of the Software Available:

**XV. Central Library**

1. No. of books and Journals: Adequate/Not Adequate
2. Reading Room Facility: Adequate/Not Adequate

**E. COMMON ACADEMIC ACTIVITIES:**

* 1. **Ethics Committee Details**:

**i. Ethics Committee Members (**Annexure)

ii. Registration details:

**iii. Number of Ethics Committee meetings held in the year (last year):**

* 1. **Medical Education Unit :**

**i. Committee members:**

ii. Number of meetings held annually:

* 1. **Numbers of Clinico-pathology Meetings held in last year:**
	2. **Number of Death Review Meetings held in last year:**
	3. **Number of Infection Control Committee meetings held in last year:**

**F. DEATH:**

|  |
| --- |
| **Number of deaths** |
| **On the day of Assessment** | **Year 1** | **Year 2** |  **Year 3****(Last year)** |
|  |  |  |  |

**G. REMARKS OF THE ASSESSOR**

*(The Assessor may send the Confidential Remarks separately within 24 hours of the completion of the Assessment/Inspection.)*

***Annexure***

**DATA TABLE**

*(Clinical Workload of - )*

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Months** **Date** | **January** | **February** | **March** | **April** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
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