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.
2. These Forms will be updated/modified from time to time. Please download it afresh at the time of any application/submission.
3. For the purpose of Annual Disclosure Report (**Annual Self-Declaration),** the Data of previous year (1st January to 31st December) will be considered.
4. 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).
5. 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.
6. Please read the FORM carefully before filling it up. Retrospective changes in Data will not be allowed.
7. Do NOT edit or modify any part of the Form. Tampering with the format of this Form will render your submission invalid.
8. Write **N/A** where it is **not applicable**. Write **'Not Available'**, if the facility is **not available**.
9. 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.

Signature of Dean **Signature of Assessor**

10. Dean, Head of Department (HoD) and Faculty should be thoroughly well-versed with all Regulations and MSRs of NMC.
11. 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.
12. Medical College shall maintain the **Declaration Forms** who are relieved or retired during the reported year.
13. Add rows in a Table as per requirement.
14. Non-compliance/wrong declaration or fake documents will invite penalties as per NMC regulations.
15. 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.
16. 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: _____

Signature of Dean **Signature of Assessor**

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 all departments 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**	

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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				

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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*)*				

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

Signature of Dean **Signature of Assessor**

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

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Endotracheal intubation with video laryngoscopy		
Tracheostomy		
Ultrasonography		
Transcutaneous Pacing		
Regional Block		

V. Intensive Care Facility:

Total intensive care unit beds in hospital: _____
Total and high dependency beds in hospital: _____
Total Post-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: _____

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	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
1.	X-Ray Machines-Static i. ii. iii.			
2.	X-Ray Machines-Portable i. ii. iii.			
3.	X-Ray Machines-TV/Imaging facility			
4.	CT Scan (Mention slices, year of manufacturing with other specifications) i. ii.			
5.	MRI (Mention Tesla, year of manufacture with other specifications)			
6.	USG – Grey Scale (mention probes available with each machine) i. ii. iii.			
7.	USG – Colour Doppler (mention			

	probes available with each machine) i. ii. iii.			
8.	Mammography			
9.	DSA			
10.	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				

Parameter	On the day of assessment	Year 1	Year 2	Year 3 (Last Year)
(1)	**(2)**	**(3)**	**(4)**	**(5)**
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

a. General Information:

Spacing and Organization of Laboratories:	Adequate / Inadequate
Laboratory Management Information System:	Available / Not Available
Internal Quality Assurance Practiced:	Yes/No

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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 (M^2)	Equipment available
Histopathology		
Cytology / Cytopathology		
Hematology		
Fluid section		
Autopsy/ Morbid Anatomy		
Other		

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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:**

i. Total Hematology samples received and tested: _____

ii. **Number of Investigations:**

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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				

iii. **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

a. General Information:

Spacing and Organization of Laboratories:	Adequate / Inadequate
Laboratory Management Information System:	Available / Not Available
Internal Quality Assurance Practiced:	Yes/No

Signature of Dean **Signature of Assessor**

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: ----------

i. 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

a. 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			

Name of the Equipment	Numbers Available	Functional Status	Important Specifications in brief
ELISA Reader			
LCD screens			
Deep Freezer -20^0			
C Deep Freezer -80^0			
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			
ICTC DOTS			

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

Signature of Dean **Signature of Assessor**

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

XI. Obstetrics and Gynecology Department

a. Infrastructure

1. Total beds in Department	
2. Total operation theatres in the Department.	
3. Number of delivery tables	
4. 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	**X**			

Signature of Dean **Signature of Assessor**

(average of all weeks of the year)				

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.		

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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

a. Organization of the Medical Record Section:
b. Staff:
c. Details of the Software Available:

XV. Central Library

a. No. of books and Journals: Adequate/Not Adequate
b. Reading Room Facility: Adequate/Not Adequate

E. COMMON ACADEMIC ACTIVITIES:

a. **Ethics Committee Details**:

i. Ethics Committee Members (Annexure)
ii. Registration details:
iii. Number of Ethics Committee meetings held in the year (last year):

b. **Medical Education Unit :**

i. Committee members:
ii. Number of meetings held annually:

c. **Numbers of Clinico-pathology Meetings held in last year:**

d. **Number of Death Review Meetings held in last year:**

e. **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.)

Signature of Dean **Signature of Assessor**

Annexure

DATA TABLE

(Clinical Workload of - _____)

Months → Date ↓	January	February	March	April	May	June	July	August	September	October	November	December
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