STANDARD ASSESSMENT FORM- B

(DEPARTMENTAL INFORMATION)

NUCLEAR MEDICINE

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. 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	

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

Date of Inspection	**Purpose of Inspection** *(LoP for starting a course/permission for increase of seats/ Recognition of course/ Recognition of increased seats /Renewal of Recognition/Surprise /Random Inspection/ Compliance*	**Type of Inspection (Physical/ Virtual)**	**Outcome** *(LoP received/denied. Permission for increase of seats received/denied. Recognition of course done/denied. Recognition of increased seats done/denied /Renewal of Recognition done/denied /other)*	**No of seats Increased**	**No of seats Decreased**	**Order issued on the basis of inspection** *(Attach copy of all the order issued by NMC/M*

	Verification inspection/other)					*CI) as* ***Annexure***

j. 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**
	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.**

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	

Number of Isolation beds (minimum 2)	
Number of Observation beds (minimum 4)	

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. 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/Specialty (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: _____

Journal details

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

g. Departmental Research Lab:

Space	
Equipment	
Research Projects Done in past 3 years	
list Research projects in progress in research lab	

h. Equipment:

Name of Equipment	Must/ Preferable	Numbers Available	Functional Status	Comments/ Important specification in brief	Adequate Yes/No
Gamma camera					
Plannar					
SPECT					
SPECT CT					
PET / PET CT					
PET / MR					
Thyroid Uptake Probe					
Dose Calibrator					
Fume / Biohazard Hood					

Contamination Monitor					

C. SERVICES

Specialty clinics and number of patients in each, being run by the department:

No.	Name of Clinic	Weekday/s	Timings	Avg No. cases	Clinic In-charge
1	Nuclear Cardiovascular				
2	Nuclear Neurology				
3	Nuclear Nephro/Urology				
4	Nuclear Hematology				
5	Nuclear Endocrinology				
6	Nuclear Oncology				
7	Nuclear GE				
8	Any other				

D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF NUCLEAR MEDICINE:

Parameter	**Numbers**				
	On the day of assessment	**Previous day data**	**Year 1**	**Year 2**	**Year 3 (last year)**
1	2	-	3	4	5
Total numbers of Out-Patients					
Out-Patients attendance (write **Average daily Out-Patients attendance** in column 3,4,5) *					
Total numbers of new Out-Patients					
New Out Patients attendance (write average in column 3,4,5) * for Average daily New Out-Patients attendance					
Total Admissions					
Bed occupancy			X	X	X
Bed occupancy for the whole year above 75%.	X	X	Yes/No	Yes/No	Yes/No
X-rays per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)					

Ultrasonography per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)					
CT scan per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)					
MRI per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)					
Haematology workload per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)					
OPD Haematology workload per day. (write average of all working days in column 3, 4 and 5)					
Biochemistry Workload per day (OPD + IPD). (write average of all working days in column 3, 4 and 5)					
OPD Biochemistry Workload per day. (write average of all working days in column 3, 4 and 5)					
Microbiology Workload per day (OPD + IPD)... (write average of all working days in column 3, 4 and 5)					
OPD Microbiology Workload per day. (write average of all working days in column 3, 4 and 5)					
Isolation and Observation bed occupancy					
Total number of scans done					
Total number of therapies					
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. MISC.

1. **Exposure of students to Therapies / Equipment at other Centers:** Yes / No
(if yes, give details)

2. **Any Specialized service provided by the department of Nuclear Medicine:**

Signature of Dean Signature of Assessor

(Give details in space provided below)

3. Safety Protocols for monitoring and prevention of Radiation Hazards

- Radiation safety protocol*: Yes / No.
- Are they strictly enforced: Yes / No.
- Institute approved Radiation Safety Committee* Yes / No.
- Approved Radiation Safety Officer*: Yes / No.

4. AERB approved diagnostic lab & Therapy facilities*: Yes / No.

5. LoP or Approval from BARC for Radiation Therapies: Yes / No.

- Facilities for Diagnostic/Therapeutic Radioactive isotope work: Yes / No.
  (Give details in the space provided)

Note: Verify AERB & BARC certificates. Items marked with an Asterisk* are MANDATORY requirements

F. 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

ii. List of Non-teaching Staff in the department:
(Must include 2 technicians each for every Gamma camera and SPECT, if available)

Sl.	Designation	Name
1	Medical Physicist	
2	Technicians - 4	
3	Radio-pharmacist	
4	Nursing Staff	
5	Others	

iii. 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				

iv. P.G students presently studying in the Department:

Name	Joining date	Phone No	E-mail

v. PG students who completed their course in the last year:

Name	Joining date	Relieving Date	Phone no	E-mail

G. 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.	Death Audit Meetings		
8.	Physician conference/ Continuing Medical Education (CME) organized.		
10.	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:

H. 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:

Name	Result (Pass/ Fail)

d. Details of the Examination: _____
Insert video clip (5 minutes) and photographs (ten).

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

J. 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**

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.*