**STANDARD ASSESSMENT FORM FOR PG COURSESYEAR 2019-20**

**(Report in this SAF prescribed for the year 2019-20 will only be accepted)**

**SUBJECT - NUCLEAR MEDICINE**

***INSTRUCTIONS TO DEANS & ASSESSORS***

1. Please read the SAF carefully before filling it up. Retrospective changes in Data will not be allowed.
2. **Do not use Annexures. All information should be provided in SAF at appropriate place earmarked. No Annexures will be considered.**
3. Experience details should be supported by experience certificate from competent authority (from the place of work) without which it will not be considered.
4. Don’t add, alter or delete any column of SAF.
5. In case of DNB qualification name of the hospital/institution from where DNB training was done and year of passing must be provided. Simply saying National Board of Examination, New Delhi is not enough. Without these details DNB qualification holder will be summarily rejected.
6. Experience of defence service must be supported by certificate from the competent authority of the office of DGAFMS without which it will not be considered.
7. Dean will be responsible for filling all columns and signing at appropriate places.
8. If promotion is after cut-off date (i.e. after 21/07/2013 for Professor & 21/07/2014 for Associate Professor) or benefit of publications is given in promotion before cut-off date, give the list of publications immediately below the name of faculty in this format: Title of Paper, Authors, Citation of Journal, details of Indexing. Photocopies of published articles should also be submitted without which they will not be considered. Give details of **only** original research articles; Case reports, Review articles and Abstracts will not be considered and should not be included.
9. No abbreviations of the name of Medical College in the Faculty List and Declaration Forms are acceptable

**INSTRUCTIONS TO ASSESSORS:** Please ensure that only original research papers published in indexed print journals are included in the list. Remaining entries, if included, should be struck off.

1. Assessor may give any relevant remarks not shown in the assessment report on the page marked “Remarks of Assessor”. No separate confidential letter should be sent.
2. Count only those faculty & Residents who have signed in attendance sheet before 11:00 a.m. and are present for subsequent verification and are found eligible on verification and also those who are on MCI permitted leave and MCI or Court duty. Do not forget to obtain signature of faculty and residents/senior residents in faculty table in appropriate column.

**STANDARD ASSESSMENT FORM FOR POSTGRADUATE COURSES**

**(NUCLEAR MEDICINE)**

**1. Name of Institution:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MCI Reference­­­­­­­­­­­­­­­­­­­­ No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Particulars of the Assessor:- Assessment Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name ………………………………………….**

**Designation……………………………………**

**Specialty……………………………………….**

**Name & Address of Institute/College ……………..…………………………………..**

**………………………………………………….**

**………………………….……………………….**

**Residential Address (with Pin Code) ……………………………………………...….**

**………………………………………………....**

**Phone .(Off) ……………(Resi.) …………….**

**(Fax)…………………………………………...**

**Mobile No. ……………………………………**

**E-mail: ………………………………………...**

**3. (Institutional Information)**

**A). Particulars of college**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | **College** | **Chairman/****Health Secretary** | **Director/** **Dean/ Principal** | **Medical Superintendent** |
| **Name** |  |  |  |  |
| **Address**  |  |  |  |  |
| **State** |  |  |  |  |
| **Pin Code** |  |  |  |  |
| **Phone****(Off)****(Res)** **(Fax)** |  |  |  |  |
| **Mobile No.** |  |  |  |  |
| **E.mail:** |  |  |  |  |

**B). Particulars of Affiliated University**

|  |  |  |  |
| --- | --- | --- | --- |
| **Item**  | **University** | **Vice Chancellor** | **Registrar** |
| **Name** |  |  |  |
| **Address**  |  |  |  |
| **State** |  |  |  |
| **Pin Code** |  |  |  |
| **Phone****(Off)****(Res)** **(Fax)** |  |  |  |
| **Mobile No.** |  |  |  |
| **E.mail:** |  |  |  |

**STANDARD ASSESSMENT FORM FOR POSTGRADUATE COURSES**

**(NUCLEAR MEDICINE)**

**1. Name of Institution:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MCI Reference­­­­­­­­­­­­­­­­­­­­ No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Particulars of the Assessor:- Assessment Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name ………………………………………….**

**Designation……………………………………**

**Specialty……………………………………….**

**Name & Address of Institute/College ……………..…………………………………..**

**………………………………………………….**

**………………………….……………………….**

**Residential Address (with Pin Code) ……………………………………………...….**

**………………………………………………....**

**Phone .(Off) ……………(Resi.) …………….**

**(Fax)…………………………………………...**

**Mobile No. ……………………………………**

**E-mail: ………………………………………...**

**3. (Institutional Information)**

**A). Particulars of college**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | **College** | **Chairman/****Health Secretary** | **Director/** **Dean/ Principal** | **Medical Superintendent** |
| **Name** |  |  |  |  |
| **Address**  |  |  |  |  |
| **State** |  |  |  |  |
| **Pin Code** |  |  |  |  |
| **Phone****(Off)****(Res)** **(Fax)** |  |  |  |  |
| **Mobile No.** |  |  |  |  |
| **E.mail:** |  |  |  |  |

**B). Particulars of Affiliated University**

|  |  |  |  |
| --- | --- | --- | --- |
| **Item**  | **University** | **Vice Chancellor** | **Registrar** |
| **Name** |  |  |  |
| **Address**  |  |  |  |
| **State** |  |  |  |
| **Pin Code** |  |  |  |
| **Phone****(Off)****(Res)** **(Fax)** |  |  |  |
| **Mobile No.** |  |  |  |
| **E.mail:** |  |  |  |

**SUMMARY**

**Date of Assessment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Assessor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| 1. **Name of Institution**

*(Private / Government)* | ***Director / Dean / Principal****(Who so ever is Head of Institution)* |
|  | Name |  |
| Age & Date of Birth |  |
| Teaching experience |  |
| PG Degree *(Recognized/Non-R)* |  |
| Subject |  |

|  |  |
| --- | --- |
| 1. **Department inspected**
 | **Head of Department** |
|  | Name |  |
| Age & Date of Birth |  |
| Teaching experience |  |
| PG Degree *(Recognized/Non-R)* |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. (a). **Number of UG seats**
 | Recognized(Year: ) | Permitted(Year: ) | First LOP date when MBBS course was first started |
|  |  |
|  (b). **Date of last inspection for** | UG | PG |
| Purpose: | Purpose: |
| Result: | Result: |

**4**. **Total Teachers available in the Department**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Designation** | **Number** | **Name** | **Total Teaching Experience** | **Benefit of Publications in Promotion** |
| Professor |  |  |  |  |
| Assoc Professor |  |  |  |  |
| Asstt. Professor |  |  |  |  |

*Note: Count only those teachers who are physically present.*

**5. Number of Units with beds in each unit:**

**6.** Clinical workload of the Institution and Department concerned :

|  |  |  |
| --- | --- | --- |
| **Parameter** | **Entire Hospital** | **Department of Nuclear Medicine** |
| On the Day of Assessment | On the Day of Assessment | Average of 3 Days Random |
| OPD attendance **upto 2 p.m.** |  |  |  |
| New admissions |  |  |  |
| Total Beds occupied at **10 a.m.** |  |  |  |
| Total Required Beds |  |  |  |
| Bed Occupancy at **10 a.m. (%)** |  |  |  |
| Major Operations |  |  |  |
| Minor Operations |  |  |  |
| Day Care Operations |  |  |  |
| Total Number of Deliveries  |  |  |  |
| Total Caesarean Sections |  |  |  |
| Total Deaths |  |  |  |
| Casualty attendance |  |  |  |

*Put N.A. whichever is not applicable to the Department.*

**Note:**

* *OPD attendance is to be considered only upto 2 p.m. Bed occupancy is to be considered at 10 a.m. only.*
* *Investigative Data to be verified with Physical Registers in Radiodiagnosis & Central Clinical Laboratory.*
* *Data to be verified with Physical Registers in Blood Bank.*

**7. Investigative Workload of entire hospital and Department Concerned.**

|  |  |  |
| --- | --- | --- |
| **Parameter** | **Entire Hospital** | **Department of Nuclear Medicine** |
| On the Day of Assessment | On the Day of Inspection | Average of 3 Random Days |
| **Radio-diagnosis** | MRI |  |  |  |
|  | CT |  |  |  |
|  | USG |  |  |  |
|  | Plain X-rays |  |  |  |
|  | IVP/Barium etc |  |  |  |
|  | Mammography |  |  |  |
|  | DSA |  |  |  |
|  | CT guided FNAC |  |  |  |
|  | USG guided FNAC |  |  |  |
|  | Any other |  |  |  |
| **Pathology** | Histopath |  |  |  |
|  | FNAC |  |  |  |
|  | Hematology |  |  |  |
|  | Others |  |  |  |
| **Bio-Chemistry** |  |  |  |  |
| **Microbiology** |  |  |  |  |
| **Blood Units Consumed**  |  |  |  |

**8. Year-wise available clinical materials (during previous 3 years) for department of Nuclear Medicine**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S.No.** | **Parameters**  | **Year 1** | **Year 2** | **Year 3****(Last Year )** |
| 1 | Total number of patients in OPD |  |  |  |
| 2 | Total number of patients admitted (IPD) |  |  |  |
| 3 | Total Number of Major Operations |  |  |  |
| 4 | Total Number of Minor Operations |  |  |  |
| 5 | Total Number of Day Care Operations  |  |  |  |
| 6 | Total Number of Normal Deliveries  |  |  |  |
| 7 | Total Number of Operative Deliveries  |  |  |  |
| 8 | Total Number of Caesarians  |  |  |  |

*Note : Put N.A. for those coloumns not applicable to the department*

**9**. Publications from the department during last 3 years:

 *(Give only full articles published in indexed journals. No case reports or review articles be given)*

|  |
| --- |
|   |

|  |  |  |  |
| --- | --- | --- | --- |
| **10** | **Blood Bank** | License valid | Yes / NO(enclose copy) |
|  | Blood component facility available | Yes / NO(enclose copy) |
| Number of blood units stored on the inspection day |  |
| Average units consumed daily (entire hospital) |  |

**11**. Specialized services provided by the department: Adequate / not adequate

**12**. Specialized Intensive care services provided by the Dept: Adequate / not adequate

**13**. Specialized equipment available in the department: Adequate / Inadequate

**14**. Space (OPD, IPD, Offices, Teaching areas) Adequate / Inadequate

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **15** | **Library** |  | Central | Departmental |
|  |  | Number of Books pertaining to orthopedics  |  |  |
|  |  | Number of Journals |  |  |
|  |  | Latest journals available upto |  |  |

**16**. Casualty Number of Beds\_\_\_\_\_\_\_Available equipment \_\_\_\_Adequate / Inadequate

**17**. Common Facilities

* Central supply of Oxygen / Suction**:** Available / Not available
* Central Sterilization Department Adequate / Not adequate
* Laundry: Manual/Mechanical/Outsourced:
* Kitchen Gas / Fire
* Incinerator: Functional / Non functional Capacity: Outsourced
* Bio-waste disposal Outsourced / any other method
* Generator facility Available / Not available
* Medical Record Section: Computerized / Non computerized
* ICD10 classification Used / Not used

18. Total number of OPD, IPD and Deaths in the Institution and department concerned during the last one year:

|  |  |
| --- | --- |
| **In the entire hospital** | **In the department of Nuclear Med** |
| OPD |  | OPD |  |
| IPD **(Total Number of Patients admitted)** |  | IPD **(Total Number of Patients admitted)** |  |
| Deaths |  | Deaths |  |

19. Number of Births in the Hospital during the last one year:

*Note : 1) The data be verified by checking the death/birth registration forms sent by the college/hospital to the Registrar, Deaths & Births (Photocopy of all such forms be provided.)*

 *: 2) Year means calendar year (1st January to 31stDecember )*

20. Accommodation for staff Available / Not available

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **21** | **Hostel Accommodation****No.**  | UG | PG | Interns |
| Boys | Girls | Boys | Girls | Boys | Girls |
|  |  |  |  |  |  |
|  | No. of Students |  |  |  |  |  |  |
|  | No. of Rooms |  |  |  |  |  |  |
|  | Status of Cleanliness  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **22** | **Total number of PG seats in the concerned subject** |  | Recognized seats | Date of recognition | PermittedSeats | Date of permission |
| Degree |  |  |  |  |
| Diploma |  |  |  |  |

**23.** Year wise PG students admitted (in the department inspected) during the last 5 years and available PG teachers

|  |  |  |
| --- | --- | --- |
| Year | No. of PG students admitted | No. of PG Teachers available in the dept. (give names) |
| Degree | Diploma |
| 2016 |  |  |  |
| 2015 |  |  |  |
| 2014 |  |  |  |
| 2013 |  |  |  |
| 2012 |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **24** | Other PG courses run by the institution  | Course Name | No. of seats | Department |
| DNB |  |  |
| M.Sc. |  |  |
| Others |  |  |

**25.** Stipend paid to the PG students, year-wise:

|  |  |  |
| --- | --- | --- |
| **Year** | **Stipend paid in Govt. colleges by State Govt.** | **Stipend paid by the Institution** |
| Ist Year |  |  |
| IInd Year |  |  |
| IIIrd Year |  |  |

26. Whether other medical superspecialty department exits in the institution …… Yes/No

 (If yes give details)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of department | Beds/Units | When LOP for DM seats granted & Number of seats | Available faculty (Names & Designation) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*I have physically verified the beds, faculty and patients of above Super specialty departments and they have not been counted in orthopedics department inspection.*

27. List of Departmental Faculty joining and leaving after last inspection:

|  |  |  |
| --- | --- | --- |
| DESIGNATIONS | NUMBER | NAMES |
| JOINING FACULTY | LEAVING FACULTY |
| Professor  |  |  |  |
| Associate Prof. |  |  |  |
| Assistant Prof. |  |  |  |
| SR/Tutor/Demons. |  |  |  |
| Others |  |  |  |

**28. Faculty deficiency, if any**

|  |  |  |  |
| --- | --- | --- | --- |
| **Designation** | **Faculty available****(number only)** | **Faculty required** | **Deficiency, if any** |
|  |  |  |  |
| Professor |  |  |  |
| Assoc Professor |  |  |  |
| Asstt. Professor |  |  |  |
| Sr. Residents |  |  |  |
| Jr. Residents |  |  |  |
| Tutor/ Demonstrator |  |  |  |
| Any Other |  |  |  |

**29. REMARKS OF ASSESSOR**

1. please do not repeat information already provided
2. please do not make any recommendation regarding granting permission/recognition
3. if you have noticed or come across any irregularity during your assessment like fake or dummy faculty, fake or dummy patients, fudging of data of clinical material etc., please mention them here)