PART – I

(INSTITUTIONAL INFORMATION)

1. Particulars of Director / Dean / Principal:

(Who so ever is Head of Institution)

Name:

PG Degree	Subject	Year	Institution	University

Teaching Experience

Designation	Institution	From	To	Total experience
Asst. Professor				
Asst.Professor				
Asso. Professor/Reader				
Professor				
Professor& Head of Dept.				
Director				
Any Other				

2. Management/Society/Inst. Information:

01	i) Name of the Society/Institution/ College/University Department:	
	ii) Postal Address, with PIN:	
	iii) Contact Details:	
	iv) E-mail ID:	
	Hospital Information :	
	(It is mandatory for Training Centre/applying Institute to have their own functional Hospital as per norms)	
03	i) Name of the Hospital	
	ii) Nursing Home Registration No.	
	iii) Establishment Year	

04	i) Name of the College/Institute where course is to be conducted:	
	ii) List of Academic Courses/ Programme(s) run by Training Centre/Institute	
	iii) Postal Address, with PIN:	
	iv) Contact Details:	
	v) E-mail ID:	
05	Fee details: as per Annexure I (Bank/DD No./DD Date/DD Amount)	

3. Library

Total number of Books in library pertaining to concerned Fellowship subject:

Journals:

Year / Month up to which latest Indian Journals available:
Year / Month up to which latest Foreign Journals available:

Library opening times:

Reading facility out of routine library hours: available/ not available

6. Residential accommodation for Resident doctors/ Fellows: available / not available

7. Ethical Committee (Constitution)

8. Details of the proposed teaching schedule for the entire period of 1 year maybe attached –

9. .No. of Journal review meetings/seminars held every month [ ]

10. Record of meetings held during the preceding 3 years

11. Copy of the program of seminars / symposiums/lectures and demonstrations

12. List of research publications made by the departmental staff and residents during preceding 3 years in recognized journals

PEDIATRIC HEMATOLOGY ONCOLOGY

	Present	Absent
1. Pediatric Intensive care	☐	☐
2. Neonatal Intensive care	☐	☐
3. Hematology laboratory	☐	☐
4. FACSCAN :	☐	☐

5. Molecular genetics/ Cytogenetic :
6. PHO unit Director/ HOD :
7. Director/ HOD involvement
   - ☐ Patient care & Administrative
   - ☐ Administrative only
   - ☐ Patient care only
8. Additional staff ☐
9. Total no. of faculty ☐
10. Support staff on call:
11. Other support staff:
12. Laboratory facilities:
13. Pediatric Intensive care
14. Genetics
15. Blood bank
16. Radiology
17. Nuclear imaging:
18. Psychologist / Counsellors
19. Occupational / Physiotherapist
20. Cardiologist
21. Dietician

22. Sonography

23. Tumor Marker

24. Microbiology: ☐

Viral ☐

Fungal ☐

Bacterial ☐

25. Social worker
26. Endocrinologist
27. Pediatric Surgery
28. Radiotherapy

29. Nursing (Nurse: Patient Ratio)

30. Academic Activity

a. In-house staff education Regular ☐ Infrequent ☐ Absent ☐

b. Local Pediatric Hematology
Oncology Society

Conduct ☐ Participate ☐ Don't attend ☐

c. International Society Conduct ☐ Participate ☐ Don't attend ☐

d. Publications International ☐ National ☐

a. Presentations International ☐ National ☐

f. Research program

g. Workshops Conduct ☐ Participate ☐ Don't attend ☐

h. Library Text books Journals ☐ Reference books ☐

31. Other PG training Practice:

32. Intradepartmental training facilities:

33. Interdepartmental training facilities: Yes

34. POLICIES AND PROTOCOLS

	Present	Absent
Chemotherapy protocol	☐	☐
Infection control protocol	☐	☐
Pain control protocol	☐	☐
Emesis Control protocol	☐	☐
Audit patient care	☐	☐
Audit (Adverse event)		
List of procedures performed		
Patient database		
Seminars/ Journal club	Yes ☐	No ☐

ANCILLARY INFRASTRUCTURE

Molecular Genetics

Cytogenetics

Hematology Laboratory

PICU/Intensive Care Beds

Bedside X ray

Bedside Sonography

Nuclear Medicine

MRI Scan

CT Scan

24 Hour Laboratory Support

24 Hour Pharmacy

Central Sterilization Unit

24 Hour ABG Monitoring

PATIENT LOAD

Hematology

Oncology

Case Mix

Books Available

Journal List

PART – II

(HOSPITAL INFORMATION)

(A)

1. **Name of the Hospital:**

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

In the entire hospital		In the department of concerned Fellowship subject	
OPD		OPD	
IPD (Total No. of Patients admitted)		*IPD (Total No. of Patients)*	

3. **Hospital Beds Distribution & No. of OTs:**

In the entire hospital	
No of Beds	
No of Beds in ICU	
No of Beds in IRCU	
No of Beds in SICU	
No of Major O.T.	
No of Minor O.T.	

4. **Available Clinical Material: (Give the data only for the department of concerned Fellowship subject)**

   No. of available for clinical service on inspection day:

Daily OPD	**On Inspection Day**	**Average of random 3 days**
Daily Admission		
Daily admission in dept. through casualty at 10 am		
Bed Occupancy in the Department at 10 am		
Percentage Bed Occupancy at 10 am		

Clinical Procedures & operative details to Fellowship Subject/Specialty::

5. **Casualty:/ Emergency Department:**

Space	
Number of Beds	
No. of cases (Average daily OPD and Admissions):	
Emergency Lab in Casualty (round the clock):	
Emergency OT and Dressing Room	
Staff (Medical/Paramedical)	
Equipment available	

6. **Blood Bank/ Blood Storage Facility:**

(i)	Valid FDA License (copy of certificate be annexed)	Yes /No	
(ii)	Blood component facility available	Yes /No	
(iii)	All Blood Units tested for Hepatitis C, B, HIV	Yes /No	
(iv)	Nature of Blood Storage facilities (as per	Yes /No	
(v)	Number of Blood Unit available on inspection day		
(vi)	Average blood units consumed daily and on inspection day in entire Hospital (give distribution in various specification)	Average daily	On inspection day
(vii)	Blood Irradiation Facility	Available	Outsourced

7. **Central Laboratory:**

Controlling Department:

No of Staff:

Equipment Available:

Working Hours:

8. **Central supply of Oxygen / Suction:** **Available / Not available**

9. **Central Sterilization Department** **Available / Not available**

10. **Ambulance (Functional)** **Available / Not available**

11. **Laundry:** **Manual/Mechanical /Outsourced:**

12. **Kitchen** **Available / Outsourced:**

13. **Incinerator: Functional / Non functional** **Capacity:……../Outsourced**

14. **Bio-Medical waste disposal** **Outsourced / any other method**

15. **Generator facility** **Available / Not available**

16. **Medical Record Section:** **Computerized is in process / Non computerized**

ICD X classification Used / Not used

PART – III

(To be filled by the Local Inquiry Committee)

(DEPARTMENTAL INFORMATION)

1.**Fellowship Specialty Department to be inspected :………………………………..**

2.**Date on which independent department of : functioning concerned specialty was created and started ………………………………..**

3. Faculty details (From start of department till date) :

Sr. No.	Name	Full Time/ Part Time	Designation	Qualification	Experience in Yrs. (after acquiring PG Qualification in concerned Subject)

5.Specialty Department Infrastructure Details:

Facility	Area (sft.)	Available	Not Available
Faculty rooms			
Clinics			
Laboratory Space			
Seminar room			
Department Library			
PG common room			
Patient waiting room			
Total area			

6.If course already started, year wise number of students admitted and available Mentors toteach students admitted to Fellowship / Certificate Course during the last 3 years:

Year	Name of the Course	No. of students admitted	No. of Mentors available in the dept. (give names)

(Local Inquiry Committee shall specifically ensure about availability of eligible/validated Mentor(s) and shall check whether the Training Center met with the Student: Mentor Ratio for the permitted Intake Capacity for each course or else it shall be reported in the Overall Remark Option.)

7. List of Non-teaching Staff in the department:

Sr.No.	Name	Designation

8. List of Equipment(s) in the department of concerned Fellowship subject:
Equipment's: List of Important equipment's available and their functional status

Sr. No.	Name of the Equipment	Specification	Functional / Not Functional	Qty.

9. Intensive care Service provided by the Departme:(Emergency)_____

10. Clinics being run in the concern speciality and number of patients in each :

Sr. No.	Name of the clinic	Days on which held	Timings	Average No. of cases attended	Name of Clinic In-charge

11.Services provided by the Department:

a) Services

i.______________________________

ii.______________________________

iii.______________________________

(b) Ancillary Services

(f) Others: ____

12.Space:

Sr. No	Details	In OPD	In IPD
1	Patient Examination/ Checking Arrangement		
2	Equipment's		
3	Teaching Space		
4	Waiting area for patients		

13. Office space:

Department Office		**Office Space for Teaching Faculty**	
Space (Adequate)	Yes/No	HOD	
Staff (Steno /Clerk).	Yes/No	Profess ors	
Computer/ Typewriter	Yes/No	Associate Profess ors	
Storage space for files	Yes/No	Assistant Profess or	
		Residents	

14. Please mention the number of seminar rooms/conference rooms with their seating capacity

Seminar Room

Meeting Room

Lecture Hall

15. Mention the names of various audio visual aids available in the seminar/conference rooms:

LCD Projector

Video Player

Web Casting Facility, Telemedicine Facility

Television

Black Board / White Board

16. Procedures …….. Per day

17. Overall Impression: ***<u>(To be filled by the Local Inquiry Committee)</u>***

Particular	Deficient	Satisfactory
Infrastructure		
Clinical Material		
Staff Assessment		
Student Assessment		
Library facilities		
Equipment		
Overall Department Assessment		

18.Any Other Observations & Overall Remarks of The Local Inquiry Committee (Not More Than 3 Lines):***<u>(To be filled by the Local Inquiry Committee)</u>***

Sr. No.	Particular	-	
01.	Recommendation for Recognition of the Institute (If applicable)	:	____________ ____________ ____________
02.	Recommendation for Starting New Fellowship / Certificate Courses (If applicable)	:	____________ ____________ ____________
03.	Recommendation for Existing Fellowship/ Certificate Courses For Continuation of Recognition/ Affiliation (If applicable)	:	____________ ____________ ____________
04.	Recommendation for Increase in Intake of Fellowship / Certificate Courses (If applicable)	:	____________ ____________ ____________

	Name of the LIC Chairman/Members	**Signature**
1		
2		
3		
4		