ANNEXURE-"A"

Professional Teaching Experience Certificate for Fellowship/Certificate Courses Director/Mentor

Title of the Course applied for:-

This to Certify that Dr Sushil Kumar Patil ... has worked in the Department of ...Dr. Vinayakrao Patil Multi-speciality Hospital... Training Centre as per following details

A) General Experience

Designation	From	To	Total period Year/Months	
Senior Consultant	2019	2025	6 years.	

B) Actual experience in the subject of concerned Fellowship/Certificate Course applied for :-

Designation	From	To	Total period Year/Months	
Senior Consultant	2019	2025	6 years.	

(It is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in the Subject of concerned Fellowship/Certificate Course)

Sign & Stamp
Head of the Department
Date

Mentor
Dr. Vinayakrao Patil Multispeciality
Hospital Deoni Dist.Latur
Dr.Sushil Kumar Patil
MBBS,MD Radiology
Reg. No 2007/08/3218

Sign & Stamp
Dean/Principal/Head of Institute
Date

Director
Dr. Nitin Joshi
Dr. Vinayakrao Patil Multispeciality
Hospital, Deoni Dist.Latur

ANNEXURE – "B"

(INSTITUTIONAL INFORMATION)

1. Particulars of Director / Dean / Principal: *(Who so ever is Head of Training Centre)*

Name: Dr. Nitin Todkar Age: 47 (Date of Birth) 22/7/1978

PG Degree	Subject	Year	Institution	University
Recognized / Not Recognized	(Gastro enterology)	2013	DNB (NBE) - ACCM (MBBS) & MUHS	NBE (Gastro enterology) - MUHS. (MBBS)

Teching Experience Gen. Med. 2007

Designation	Institution	From	To	Total Exp.
Asst. Professor				
Asso. Professor/Reader				
Professor				
Any Other				
			Gran d Total	

2. Management/Society/Inst. Information:

01	i) **Name of the Society/Institution/ Training Centre /University Dept.:**	Dr. Vinayakrao Patil Multispeciality Hospital
	ii) Postal Address, with PIN:	Udgir-Nilanga Road, Deoni, Pin 413519
	iii) Contact Details:	Mob: 9529256830 Tele:
02	**Society/Institution/ Training Centre Registration Number and date:**	i) Public Trust Act 1950: ...Einstep Foundation ii) Society's Registration Act.1860: Section 8 of Company Act 2013 iii) Year of establishment: 2017. iv) Copies of Registration, Constitution and Memorandum of Association attached? *Yes/No– Marked as Appendix 'A'
03	**Hospital Information :** ***(It is mandatory for Training Centre/applying Institute to have their own functional Hospital as per norms)*** i) .Name of the Hospital ii) Nursing Home Registration No. iii) Establishment Year	Dr. Vinayakrao Patil Multispeciality Hospital 108/2022 2022 – Mark as Appendix 'B'
04	**i) Name of the Training Centre /Institute where course is to be conducted:**	Dr. Vinayakrao Patil Multispeciality Hospital.
	ii) Postal Address, with PIN: iii) Contact Details: iv) E-mail ID:	Udgir-Nilanga Road Deoni Dist-Latur Pin:413519 Mob: 9284989822 Tele: - director@drvinayakraopatilhosp.com
	v) List of University approved Fellowship/Certificate Course(s) **conducted / already running** at Training Centre with Intake Capacity	**Name of the Course(s) …….. Approved Intake Capacity… … … Affiliated Since… … (if necessary Attach separate List)**
	vi) Training Centre / Institute **willing/desirous to Start/Open** Fellowship/Certificate Course(s) (For New Opening Purpose only)	**Name of the Course(s) …… Required Required Intake Capacity …….(if necessary Attach separate List)**
05	Affiliation Fees details: (Bank/DD no./ date/amount/ NEFT/RTGS)	Paid Fees details Attached: *Yes/No. (Pending Fees, if any ;)
06	Financial position of the Society/ Institute in the preceding 03 years:	Audited Statements of Accounts for *Yes/No– Mark as Appendix 'C'
07	Budgetary provision for the FC/CC/DC for the next 03 years	i) 20 . . . - . . . Rs ……,
08	Management Resolution seeking Recognition of Institute for FC/CC/DC of MUHS, Nashik:	Resolution No. . . . . Dated . . . . . Copy of Management Resolution attached? *Yes/No– – Mark as Appendix 'D'

09	**Other Information:**	
	a) Land:	
	i) Whether the land is owned by the Applicant Institute/Training Centre/ Trust:	*Yes/No. If yes, then Area: 129.05 sq ft Copy of land documents i.e. 7/12 extract, Property Card, etc. attached? *Yes/No– Mark as Appendix 'E'
	ii) Whether the land is registered?	*Yes/No. If yes, Registration Number: 0.0.300.6330/1 Dated 8.11.2021 At (Place): Deoni Copy of Land Registration Certificate attached? *Yes/No.– Mark as Appendix 'F'
	iii) Any loans, mortgage, etc. shown against the title of the land:	*Yes/No. If yes, amount of loan Rs. /mortgaged for Rs ..... Copy of Loan/Mortgage Deed attached? *Yes/No. – Mark as Appendix 'G'
	b) Building: i) Total built-up area:	129.05 sq. ft. Certified copy of Building Plan attached? *Yes/No – Mark as Appendix 'H'

3. **Central Library**

- Total number of Books in library: 100
- Books pertaining to concerned Fellowship subject: 11
- Purchase of latest editions of concerned books in last 3 years: -
- Journals:

1	Journals		Total	concerned Fellowship subject
2	Indian			
3	Foreign			

- Year / Month up to which latest Indian Journals available : _____
- Year / Month up to which latest Foreign Journals available : _____
- Internet / Med pub / Photocopy facility: available / not available
- Library opening times: _____
- Reading facility out of routine library hours: available / not available

(Obtain list of books & journals duly signed by Dean)

4. **Recreational facilities:** **Available / Not available**

- Play grounds Gymnasium

5. **Hostel Accommodation:**

Particular	UG		PG		Interns	
	Boys	Girls	Boys	Girls	Boys	Girls
No. of Rooms No. of						
Students			6	9		
Status of Cleanliness			24	18		

6. **Residential accommodation for Staff / Paramedical staff :** Available /Not Available

7. **Ethical Committee (Constitution) :** YES / NO

8. **Medical Education Unit (Constitution) :** YES / NO
(Specify number of meetings held annually & minutes thereof)

9. **Any other faculty specific information required :**
(such as Herbal garden / PanchakarmaUnit/Pharmacy / Dental Chairs and Units/as per the requirement of concerned Course) Attach details)

ANNEXURE – "C"

HOSPITAL INFORMATION

1. Name of the Hospital: Dr. Vinayakrao Patil Multispecialty Hospital

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

– In the entire hospital		In the department of concerned Fellowship subject	
OPD	21000	OPD	1702
IPD (Total No. of Patients admitted)	1744	IPD (Total No. of Patients admitted)	634

3. Hospital Beds Distribution & No of O.T.:

	In the entire hospital
No of Beds	150
No of Beds in ICU	10
No of Beds in IRCU	5
No of Beds in SICU	5
No of Major O.T.	3
No of Minor O.T.	

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

- No. of available for clinicalservice on inspection day:

	On Inspection day	Average of random 3 days
• Daily OPD – 2 PM	22	26
• Daily admissions	5	5
• Daily admissions in Dept.	21	2
• Through casualty at 10am	2	3
• Bed occupancy in the Dept.	10	12
• Number of patients in ward (IPD)at 10AM	107	107
• Percentage bed occupancy at 10Am	20%	20%

- Clinical Procedure(s) & Operative Details related to Fellowship subject/Specialty :

(For further details in this concern, kindly peruse the Guidelines information sheet supplied herewith)

	On Inspection day	Average of random 3 days
•		24
•		5
•		2
•		3
•		12

5. Casualty:/ Emergency Department :

Space	
Number of Beds	10
No. of cases (Average daily OPD and Admissions):	15
Emergency Lab in Casualty (round the clock):	available / not available
Emergency OT and Dressing Room	Yes
Staff (Medical/Paramedical)	Yes
Equipment available	Yes

6. Blood Bank : → Tie up MOU ~~Annexed~~

(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 specifications)	Yes / No	
(v)	Number of Blood Units available on inspection day		
(vi)	Average blood units consumed daily and on inspection day in the entire Hospital (give distribution in various specialties)	Average daily	On Inspection day

7. Central Laboratory:

- Controlling Department: Yes
- No of Staff : 6
- Equipment Available : Attach separate List
- Working Hours: 24 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/ Not Available

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 / Non computerized

- ICD X classification Used / Not used

Sign & Stamp
Head of the Department
Date: Date:

Dr.Sushil Kumar Patil
MBBS,MD Radiology
Reg. No 2007/08/3218

Sign & Stamp
Dean/ Principal/Director of Training Centre
Dr. Nitin Joshi
Dr. Vinayakrao Patil Multispeciality Hospital, Deoni Dist.Latur

Training Centre Round Seal

Dr. Vinayakrao Patil Multispeciality Hospital (Subdivision of Medoquick Private Limited)

ANNEXURE – "D"

DEPARTMENTAL INFORMATION

(If required Use Separate Sheet for each Department / Fellowship/Certificate Course)

1. Fellowship Specialty Department to be inspected: Radiology Technology
2. Date on which independent department of: functioning concerned specialty was created and started ..... 2023 .....
3. Mentor's 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)
1	Sushilkumar Patil	Part time	Sr Consultant	MBBS MD Radiology	10 years.

4. Whether Independent Department of concerned Fellowship subject exists in the Institution :
   Yes/No: ..... Since when: 2023.....
5. Specialty Department Infrastructure Details :

Facility	Area (sft.)	Available	Not Available
Faculty rooms	400	✓	
Clinics	400	✓	
Laboratory Space	500	✓	
Seminar room	500	✓	
Department Library	500	✓	
PG common room	1000	✓	
Pre-clinical lab (where ever applicable)	400	✓	
Patient waiting room	600	✓	
Total area	4300.		

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

Year	Name of the Course	No. of students admitted	No. of Valid Mentors available in the dept. (give names)
2024-25	Radiography Technology	1	1 - Dr Sushilkumar Patil

(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 Staffin the department:

Sr. No.	Name	Designation
1	Saraswati Patil	Clerk

8. List of Equipment(s) in the department of concerned Fellowship subject: Equipment's: List of Important equipment's available and their functional status (List here only- No annexure to be attached)

Sr. No.	Name of the Equipment	Specification	Functional / Not Functional	Qty.
1	X-ray	Allengers	✓	1
2	USG	Philips	✓	1

9. **Intensive care Service provided by the Department:** (Emergency)

10. **Specialty clinics being run by the department 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
1	Radiography Technology	Thursday	11:00-1pm	8	Dr Sushil Kumar Pasi

11. **Services provided by the Department:**

a) Services

i. X-ray

ii. USG

iii. CT/MRI

(b) Ancillary Services

(f) Others: _____

12. **Space:**

Sr. No	Details	In OPD	In IPD
1	Patient Examination/ Checking Arrangement	400 Sqft	600 Sq ft
2	Equipment's	400 Sq ft	600 Sq ft
3	Teaching Space	500 Sq ft.	500 Sq ft
4	Waiting area for patients	600 Sq. ft	600 Sq ft

13. **Office space:**

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

14. **Clinical Load of Dept.: No of Surgeries / Procedures**.....8..... **Per day**

15. **Submission of data to National Authorities if any :** ----------

ANNEXURE – "E"

Information of Director of Training Centre

It shall be verified by the Head of the concerned Training Center.

Sr. No.	Particular	-	Information to be filled
01.	Name of the Director	:	Dr. Nitin Joshi
02.	Date of Birth	:	22/7/1978
03.	Address	:	Talegaon, Deoni, Latur
04.	Tel. No./ Mob. No.	:	9284989822
05.	E-mail id	:	director@eimstepfoundation.org
06.	Nationality	:	Indian
07.	Qualification in details : (attach documentary proof)	:	MBBS DNB (Gen. Med) DNB (Gastroenterology)
08.	Teaching Experience / Health Sciences: Profession Experience (Attached document proof with signature of Head of the Institute. Also it is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in the Subject of concerned Fellowship/Certificate Course)	:	2007 to 2025 - 18 years.
09.	Present Appointment	:	Director
10.	Publications (List & Proof)	:	2
11.	Post Graduate Teaching experience (Attach documentary evidence)	:	7yrs
12.	Any other relevant information	:	–

Date: -

Name & Sign. of Director

N. Joshi

Director
Dr. Nitin Joshi
Dr. Vinayakrao Patil Multispeciality Hospital, Deoni Dist.Latur

For the use of affiliated Training Center:

I have verified the eligibility of the above Director as per the criteria of eligibility prescribed by the University vide clause no.7 of the University Direction No. 05/2017 (Amended).

Sign & Stamp
Head of the Department
Date:

Dr. Sushil Kumar Patil
MBBS,MD Radiology
Reg. No 2007/08/3218

Training Centre Round Seal

Dr. Vinayakrao Patil Multispeciality Private Limited Hospital (Subdivision of Medical College)

Sign & Stamp
Dean/ Principal/ Director of Training Centre
Date:

Director
Dr. Nitin Joshi
Dr. Vinayakrao Patil Multispeciality Hospital, Deoni Dist.Latur

ANNEXURE – "F"

Information of Mentor of Training Centre

It shall be verified by the Head of the concerned Training Center,

Sr. No.	Particular		Information to be filled
01.	Name of the Mentor	:	Dr. Sushil Kumar Patil
02.	Date of Birth	:	27/5/1984
03.	Address	:	1801, Satyam Imperial Heights, Sector 11, Ghansoli, Navi Mumbai - 400 701
04.	Tel. No./ Mob. No.	:	9960076180
05.	e-mail id	:	dr.sushil.patil@gmail.com
06.	Nationality	:	Indian
07.	Qualification in details : (attach documentary proof)	:	MBBS, MD Radiology, Fellowship in Interventional Radiology
08.	Teaching Experience / Health Sciences: Profession Experience (Attached document proof with signature of Head of the Institute. Also it is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in the Subject of concerned Fellowship/Certificate Course)	:	10 yrs
09.	Present Appointment	:	Senior Consultant
10.	Publications (List & Proof)	:	2
11.	Post Graduate Teaching experience (Attach documentary evidence)	:	4
12.	Any other relevant information	:	–

Date: -

Name & Sign. of Mentor

Dr.Sushil Kumar Patil
MBBS,MD Radiology
Reg. No 2007/08/3218

For the use of affiliated Training Center:

I have verified the eligibility of the above Mentor as per the criteria of eligibility prescribed by the University vide clause no.7 of the University Direction No. 05/2017 (Amended) and University Circular No. MUHS/UDC/FCCC/736/2019 dated 30/09/2019.

Sign & Stamp
Head of the Department
Date:

Dr.Sushil Kumar Patil
MBBS,MD Radiology
Reg. No 2007/08/3218

Sign & Stamp
Dean/ Principal/ Director of Training Centre
Date:

Director
Dr. Nitin Joshi
Dr. Vinayakrao Patil Multispeciality Hospital, Deoni Dist.Latur

Training Centre Round Seal

Dr. Vinayakrao Patil Multispeciality Hospital (Subdivision of Medquick Private Limited)

ANNEXURE – "G"

Information of Co-ordinator of Training Centre

It shall be verified by the Head of the concerned Training Center,

Sr. No.	Particular		Information to be filled
01.	Name of the Co-ordinator	:	Dr. Hitendra G. Patil
02.	Date of Birth	:	14/6/1983
03.	Address	:	Shivaji Society, Udgir
04.	Mob. No.	:	9833164740
05.	E-mail id	:	hitendrapatil@kem.edu
06.	Nationality	:	Indian
07.	Qualification in details : (attach documentary proof)	:	MBBS DNB (Ortho)
08.	Present Appointment	:	~~Surgeon~~ Senior Consultant, Coordinator.
09.	Any other relevant information		-

Hitendra Patil

Sign. of Co-ordinator

Date:

Dr Hitendra Patil
Co-Ordinator
Dr. Hitendra Patil
Dr. Vinayakrao Patil Multispeciality Hospital, Deoni Dist.Latur

Sign & Stamp
Head of the Department
Date:

Dr.Sushil Kumar Patil
MBBS,MD Radiology
Reg. No 2007/08/3218

Sign & Stamp
Dean/ Principal/ Director of Training Centre
Date:

Dr. Nitin Joshi
Director
Dr. Nitin Joshi
Dr. Vinayakrao Patil Multispeciality Hospital, Deoni Dist.Latur

Training Centre Round Seal

Dr. Vinayakrao Patil Multispeciality Hospital (Subdivision of Medoquick Private Limited)

ANNEXURE – "II"

DECLARATION

I, the Dean / Director/ Principal of the Dr. Vinayakrao Patil Multispeciality Hospital, Training Centre / Institute solemnly states on affirmation, that the information provided by me in Inspection Format as well as uploaded on Training Centre Website along-with all Annexures is true and correct to the best of my knowledge. The said information is provided to me by the concerned teachers and duly verified by me. It is further submitted the teacher's information attached in respective **Annexure-.... &** are not working in / at any other Training Centre /Institute or presented themselves at any inspection for the Academic Year **20.....-20.....**, as per my knowledge and information provided by the concerned teachers. The teachers in the **Annexure-.... &** are staying in the same city / town / village where the Training Centre/ Institute is situated or adjacent to the city / town / village, where the Training Centre /Institute is situated and having the valid proof of residence of the said city / town / village. The teachers in the **Annexure-.... &** are not practicing in Training Centre working hours or out-side the City where the Training Centre /Institute is situated.

I am further hereby declare that every information or contents in this LIC Format is based on the information provided by the concerned teachers and endorsed by me after due verification and the same is/are absolutely true and correct. If at any stage it is revealed that any information or content given in this declaration is not true and correct, in such event the undersigned/ the concerned teacher as the case may be, shall be liable for disciplinary action or penal action or Affiliation of the Training Centre shall be withdrawal, as the case may be.

This declaration is voluntarily signed by me on..... Day of .....20..... At.....

Date: .....

Place: .....Deoni...

N Joshi

Signature of Dean/Principal/Director
Name of the Signatory
(With Seal of the Training Centre)

Director
Dr. Nitin Joshi
Dr. Vinayakrao Patil Multispeciality
Hospital, Deoni Dist.Latur

This declaration is voluntarily signed by me on..... Day of .....20..... At.....