

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

Title of the Course applied for:-

This to Certify that Dr. Mayur Nagvekar has worked in the Department of Dr. Vinayakrao Patil Multispeciality Hospital. Training Centre as per following details

## A) General Experience

| Designation       | From | To   | Total period<br>Year/Months |  |
|-------------------|------|------|-----------------------------|--|
| Senior Consultant | 2019 | 2025 | 8 years                     |  |
|                   |      |      |                             |  |

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

| Designation       | From | To   | Total period<br>Year/Months |  |
|-------------------|------|------|-----------------------------|--|
| Senior Consultant | 2019 | 2025 | 8 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. Mayur A Nagvekar**

MBBS, MS (General Surgeon)

DNB Surgical Gastroenterology

Reg. No. 2005/02/0720

Sign & Stamp

Dean/Principal/Head of Institute

Date

Director

**Dr. Nitin Joshi**

Dr. Vinayakrao Patil Multispeciality  
Hospital, Deoni Dist. Latur

## (INSTITUTIONAL INFORMATION)

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

Name: Dr. Nisha Joshi Age: 47 (Date of Birth) 22/7/1978

| PG Degree                   | Subject           | Year        | Institution | University |
|-----------------------------|-------------------|-------------|-------------|------------|
| Recognized / Not Recognized | <u>Genito</u>     | <u>2013</u> | <u>DNB</u>  | <u>NBE</u> |
|                             | <u>Enterology</u> | <u>2017</u> | <u>DNB</u>  | <u>NBE</u> |

| Designation            | Institution | From | To | Total Exp. |
|------------------------|-------------|------|----|------------|
| Asst. Professor        |             |      |    |            |
| Asso. Professor/Reader |             |      |    |            |
| Professor              |             |      |    |            |
| Any Other              |             |      |    |            |
| Grand Total            |             |      |    |            |

2. Management/Society/Inst. Information:

|    |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 01 | i) Name of the Society/Institution/<br>Training Centre /University Dept.:<br>ii) Postal Address, with PIN:<br>iii) Contact Details:                                                                                                                                                                                                                                                                                                                  | <u>Udgar-Nilanga Road, Deoni 413519</u><br>Mob: _____ Tele: _____                                                                                                                                                                                                                                                                                                                                                                                            |
| 02 | Society/Institution/ Training Centre<br>Registration Number and date:                                                                                                                                                                                                                                                                                                                                                                                | i) Public Trust Act 1950: <u>Emstep Foundation</u><br>ii) Society's Registration Act.1860: <u>Section 8 company A.L.</u><br>iii) Year of establishment: <u>2017</u><br>iv) Copies of Registration, Constitution and<br>Memorandum of Association attached? *Yes/No-<br>Marked as Appendix 'A' <u>✓</u>                                                                                                                                                       |
| 03 | Hospital Information :<br>(It is mandatory for Training<br>Centre/applying Institute to have their<br>own functional Hospital as per norms )<br>i) Name of the Hospital<br>ii) Nursing Home Registration No.<br>iii) Establishment Year                                                                                                                                                                                                              | <u>Dr. Vinayakrao Patil Multispecialty</u><br><u>Hospital</u><br>.....<br><u>10.8/2022</u> .....<br><u>2022</u> ..... - Mark as Appendix 'B'                                                                                                                                                                                                                                                                                                                 |
| 04 | i) Name of the Training Centre /Institute<br>where course is to be conducted:<br>ii) Postal Address, with PIN:<br>iii) Contact Details:<br>iv) E-mail ID:<br>v) List of University approved<br>Fellowship/Certificate Course(s)<br>conducted / already running at<br>Training Centre with Intake Capacity<br>vi) Training Centre / Institute<br>willing/desirous to Start/Open<br>Fellowship/Certificate Course(s)<br>(For New Opening Purpose only) | <u>Dr. Vinayakrao Patil Multispecialty</u><br><u>Hospital</u><br><u>Udgar-Nilanga road, Deoni, Latur</u><br>Mob: <u>92844 89822</u> Tele: <u>613519</u><br><u>director @ dr.vinayakrao patil Hosp. .com</u><br>Name of the Course(s) .....<br>Approved Intake Capacity... .. Affiliated Since... .. (if<br>necessary Attach separate List)<br>Name of the Course(s) .....Required<br>Required Intake Capacity .....(if<br>necessary<br>Attach separate List) |
| 05 | Affiliation Fees details: (Bank/DD no./<br>date/amount/ NEFT/RTGS)                                                                                                                                                                                                                                                                                                                                                                                   | Paid Fees details Attached: *Yes/No.<br>(Pending Fees, if any ;)                                                                                                                                                                                                                                                                                                                                                                                             |
| 06 | Financial position of the Society/<br>Institute in the preceding 03 years:                                                                                                                                                                                                                                                                                                                                                                           | Audited Statements of Accounts for<br>*Yes/No- Mark as Appendix 'C'                                                                                                                                                                                                                                                                                                                                                                                          |
| 07 | Budgetary provision for the<br>FC/CC/DC for the next 03 years                                                                                                                                                                                                                                                                                                                                                                                        | i) 20 . . . . . Rs . . . . . ,                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 08 | Management Resolution seeking<br>Recognition of Institute for<br>FC/CC/DC of MUHS, Nashik:                                                                                                                                                                                                                                                                                                                                                           | Resolution No. . . . . Dated . . . . .<br>Copy of Management Resolution attached?<br>*Yes/No- - Mark as Appendix 'D'                                                                                                                                                                                                                                                                                                                                         |

|                         |                                                                                                            |                                                                                                                                                                                                        |
|-------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 09                      | <b>Other Information:</b>                                                                                  |                                                                                                                                                                                                        |
|                         | a) Land:                                                                                                   | *Yes/No. If yes, then Area: ... <u>1.29.05</u> sq. ft.                                                                                                                                                 |
|                         | i) Whether the land is owned by the Applicant Institute/Training Centre/Trust:                             | 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: <u>003.00.6.3301</u><br>Dated <u>8.11.2023</u> (Place): .....<br>Copy of Land Registration Certificate attached? <u>Acari</u><br>*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. ....<br>Copy of Loan/Mortgage Deed attached? *Yes/No.<br>- Mark as Appendix 'G'                                                                 |
| b) Building:            |                                                                                                            |                                                                                                                                                                                                        |
| i) Total built-up area: | <u>1290.3</u> sq. ft.<br>Certified copy of Building Plan attached? <u>Yes/No</u><br>- Mark as Appendix 'H' |                                                                                                                                                                                                        |

### 3. Central Library

- Total number of Books in library: 100
- Books pertaining to concerned Fellowship subject: 10
- Purchase of latest editions of concerned books in last 3 years: - 5

#### Journals:

|   | Journals | Total    | concerned Fellowship subject |
|---|----------|----------|------------------------------|
| 1 | Indian   | <u>3</u> | <u>2</u>                     |
| 2 | Foreign  | <u>2</u> | <u>1</u>                     |

- Year / Month up to which latest Indian Journals available : \_\_\_\_\_

- Year / Month up to which latest Foreign Journals available : \_\_\_\_\_

- Internet / Med pub / Photocopy facility: available -

✓ available / not

- Library opening times: 9.00 am to 6 pm

- Reading facility out of routine library hours: available

✓ available / not

(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 / Panchakarma Unit/Pharmacy / Dental Chairs and Units/as per the requirement of concerned Course) Attach details)

## HOSPITAL INFORMATION

1. Name of the Hospital: Dr. Vinayakrao Chit. Multi specialty 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                                  | 21000 | OPD                                               | 1200 |
| IPD (Total No. of Patients admitted) | 1682  | IPD (Total No. of Patients admitted)              | 264  |

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

| In the entire hospital |    |
|------------------------|----|
| No of Beds             | 15 |
| 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.       | 2  |

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

- No. of available for clinical service 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.                | 1                 | 2                        |
| • Through casualty at 10am                 | 2                 | 3                        |
| • Bed occupancy in the Dept.               | 10                | 12                       |
| • Number of patients in ward (IPD) at 10AM | 3                 | 3                        |
| • 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 |
|---|-------------------|--------------------------|
| • | 1                 | 1                        |
| • | 1                 | 1                        |
| • |                   |                          |
| • |                   |                          |
| • |                   |                          |

5. Casualty:/ Emergency Department :

|                                                  |                             |
|--------------------------------------------------|-----------------------------|
| Space                                            |                             |
| Number of Beds                                   |                             |
| No. of cases (Average daily OPD and Admissions): | 195                         |
| 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 :

|       |                                                                                                                                |                                    |
|-------|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| (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<br>( give distribution in various specialties) | Average daily<br>On Inspection day |

7. Central Laboratory:

- Controlling Department: Yes
- No of Staff : 6
- Equipment Available : Attach separate List
- Working Hours: 24 hrs

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

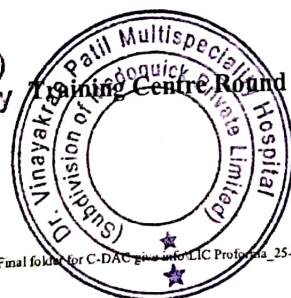
Used / Not used

Sign & Stamp

Head of the Department

Date: 24/02/2020

Dr. M. S. Patil  
MBBS, MS. (General Surgeon)  
DNB Surgical Gastroenterology  
Reg. No. 2005/02/0720



Sign & Stamp

Dean/ Principal/ Director of Training Centre

Dr. Nitin Joshi  
Dr. Vinayakrao Patil Multispecialty  
Hospital, Deoni Dist. Latur

## DEPARTMENTAL INFORMATION

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

1. Fellowship Specialty Department to be inspected:.....Colorectal Surgery.....  
 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/<br>Part Time | Designation          | Qualification | Experience in Yrs.<br>(after acquiring PG<br>Qualification in<br>concerned Subject) |
|---------|----------------|-------------------------|----------------------|---------------|-------------------------------------------------------------------------------------|
|         | Mayur Nagvekar | Full<br>time            | Senior<br>Consultant | MBBS,<br>MS   | 6 yrs                                                                               |

4. Whether Independent Department of concerned Fellowship subject exists in the Institution :  
 Yes/No: ..... Since when: .....

## 5. Specialty Department Infrastructure Details :

| Facility                                    | Area (sft.) | Available | Not Available |
|---------------------------------------------|-------------|-----------|---------------|
| Faculty rooms                               | 600         | ✓         |               |
| Clinics                                     | 400         | ✓         |               |
| Laboratory Space                            | 500         | ✓         |               |
| Seminar room                                | 500         | ✓         |               |
| Department Library                          | 500         | ✓         |               |
| PG common room                              | 1000        | ✓         |               |
| Pre-clinical lab<br>(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 3 years:

| Year    | Name of the Course | No. of students admitted | No. of Valid Mentors available in the dept.<br>(give names) |
|---------|--------------------|--------------------------|-------------------------------------------------------------|
| 2024-25 | Breast Surgery     | 1                        | Mayur Nagvekar                                              |

(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 |
|---------|--------------|-------------|
| 1)      | Suvama 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)      | Laparoscopy           | Styker        | Functional                  | 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 |
|---------|--------------------|--------------------|---------|-------------------------------|--------------------------|
|         | Colorectal Surgery | Friday             | 9-4 pm  | 4                             | Mayur Magrekar           |

11. Services provided by the Department:

a) Services

- i Surgery
- ii Colonoscopy
- iii

(b) Ancillary Services

(f) Others: -

12. Space:

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

13. Office space:

| Department Office       |        | Office Space for Teaching Faculty |     |
|-------------------------|--------|-----------------------------------|-----|
| Space (Adequate)        | Yes/No | HOD                               | 200 |
| Staff (Steno /Clerk).   | Yes/No | Professors                        | 200 |
| Computer/ Typewriter    | Yes/No | Associate Professors              | 200 |
| Storage space for files | Yes/No | Assistant Profess or              | 200 |
|                         |        | Residents                         | 200 |

14. Clinical Load of Dept.: No of Surgeries / Procedures.....2..... Per day

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

# 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                                                                                                                                                                                                                                                                                | Nitin Joshi                                   |
| 02.     | Date of Birth                                                                                                                                                                                                                                                                                       | 22/7/1978                                     |
| 03.     | Address                                                                                                                                                                                                                                                                                             | Talegaon, Deoni, Latur                        |
| 04.     | Tel. No./ Mob. No.                                                                                                                                                                                                                                                                                  | 902824 2922                                   |
| 05.     | E-mail id                                                                                                                                                                                                                                                                                           | director@emstepfoundation.org                 |
| 06.     | Nationality                                                                                                                                                                                                                                                                                         | Indian                                        |
| 07.     | Qualification in details :<br>(attach documentary proof)                                                                                                                                                                                                                                            | MBBS, DNB (Gen Med)<br>DNB (Gastroenterology) |
| 08.     | Teaching Experience / Health Sciences:<br>Profession Experience<br>(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) | 17 years                                      |
| 09.     | Present Appointment                                                                                                                                                                                                                                                                                 | Medical Director                              |
| 10.     | Publications (List & Proof)                                                                                                                                                                                                                                                                         | 2                                             |
| 11.     | Post Graduate Teaching experience<br>(Attach documentary evidence)                                                                                                                                                                                                                                  | 7                                             |
| 12.     | Any other relevant information                                                                                                                                                                                                                                                                      | -                                             |

Date: -

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).

Name & Sign. of Director  
Director

Dr. Nitin Joshi

Dr. Vinayakrao Patil Multispeciality  
Hospital, Deoni Dist. Latur

Sign & Stamp

Head of the Department

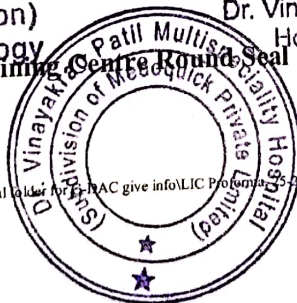
Dr. Mayur A. Nagvekar  
Date: MBBS, MC, (General Surgeon)  
DNB Surgical Gastroenterology  
Reg. No. 2005/02/0720

Sign & Stamp

Dean/ Principal/ Director of Training Centre

Date: Dr. Nitin Joshi

Dr. Vinayakrao Patil Multispeciality  
Hospital, Deoni Dist. Latur



# 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                                                                                                                                                                                                                                                                                  | Mayor Nagvekar                   |
| 02.     | Date of Birth                                                                                                                                                                                                                                                                                       | 18/12/1981                       |
| 03.     | Address                                                                                                                                                                                                                                                                                             | Talegaon, Deoni                  |
| 04.     | Tel. No./ Mob. No.                                                                                                                                                                                                                                                                                  | 9225582865                       |
| 05.     | e-mail id                                                                                                                                                                                                                                                                                           | director @ emshap Foundation.org |
| 06.     | Nationality                                                                                                                                                                                                                                                                                         | Indian                           |
| 07.     | Qualification in details :<br>(attach documentary proof)                                                                                                                                                                                                                                            | MBBS, MS.                        |
| 08.     | Teaching Experience / Health Sciences:<br>Profession Experience<br>(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) | 8 years                          |
| 09.     | Present Appointment                                                                                                                                                                                                                                                                                 | Mentor                           |
| 10.     | Publications (List & Proof)                                                                                                                                                                                                                                                                         | 2                                |
| 11.     | Post Graduate Teaching experience<br>(Attach documentary evidence)                                                                                                                                                                                                                                  | 8 years                          |
| 12.     | Any other relevant information                                                                                                                                                                                                                                                                      |                                  |

Date: -

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 &amp; Stamp

Head of the Department

**Dr. Mayur A Nagvekar**  
MBBS, MS. (General Surgeon)  
DNB Surgical Gastroenterology

Reg. No. 2005/02/0720

Sign &amp; Stamp

Dean/ Principal/ Director of Training Centre

Date: Dr. Nitin Joshi

Dr. Vinayakrao Patil Multispeciality  
Hospital, Deoni Dist. Latur



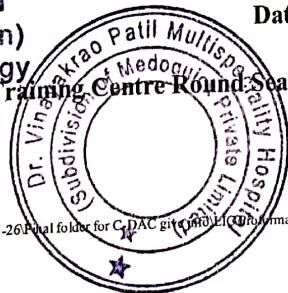
# ANNEXURE - "G"

## 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, Mdg         |
| 04.     | Mob. No.                                                 | 9833 164 740                 |
| 05.     | E-mail id                                                | directu @ einstep foundation |
| 06.     | Nationality                                              | Indran                       |
| 07.     | Qualification in details :<br>(attach documentary proof) | MBBS, DNB (Cardio)           |
| 08.     | Present Appointment                                      | Coordinator                  |
| 09.     | Any other relevant information                           | —                            |

Date:

Sign & Stamp  
Head of the Department  
Dr. Nitin Joshi  
MBBS, MS, (General Surgeon)  
DNB Surgical Gastroenterology  
Reg. No. 2005/02/0720



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

**DECLARATION**

I, the Dean / Director/ Principal of the.....Dr. Vinayakrao Patil Multispecialty  
 Training Centre / Institute solemnly states on affirmation, that the information provided by me in the  
 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.....

Dr. Nitin Joshi  
 Signature of Dean/Principal/Director  
 Name of the Signatory  
 (With Seal of the Training Centre)  
Dr. Nitin Joshi  
 Dr. Vinayakrao Patil Multispecialty  
 Hospital, Deoni Dist. Latur