



**CHRISTIAN MEDICAL COLLEGE, VELLORE, INDIA**

**DEPARTMENT OF INFECTIOUS DISEASES**

**FELLOWSHIP IN GENERAL INFECTIOUS DISEASES AND ANTIMICROBIAL STEWARDSHIP**

**APPLICATION FORM 2023-24**

**PART-A**

 Affix a

Photograph

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_\_\_\_\_ NATIONALITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERMANENT ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

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 PRESENT ADDRESS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Your preferred address for communication:

PERMANENT ADDRESS PRESENT ADDRESS

TELEPHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE NO\*\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 E MAIL ADDRESS\*\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(The fields marked \*\* requires extra attention while filling)

**MCI /STATE REGISTRATION NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Repeat Applicant for FGID Course: Yes/No

If Yes, Year(s) Applied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A. EDUCATION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **INSTITUTION&****UNIVERSITY** | **ADDRESS** | **PERIOD** | **DEGREE** |
| **FROM****(DATE)** | **TO****(DATE)** |  |
| **PG Degree** |  |  |  |  |  |
| **PG Diploma** |  |  |  |  |  |
| **MBBS** |  |  |  |  |  |
| **Pre-Medical** |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**AWARDS & HONORS (If any)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. WORK EXPERIENCE:**

**1) Mention your current Institution you are working & position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Joining**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Firm**: Government Private Armed Forces Mission

**2) Previous Employments:**

|  |  |  |  |
| --- | --- | --- | --- |
| **SL.NO** | **INSTITUTION & ADDRESS (Most recent ones first)** | **DESIGNATION** | **PERIOD** |
| **FROM (DATE)** | **TO (DATE)** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| **4** |  |  |  |  |
| **5** |  |  |  |  |
| **6** |  |  |  |  |

**C. PLEASE ANSWER THE FOLLOWING QUESTIONS IN A PARAGRAPH EACH:**

 (Please attach separate sheets)

1. Explain in 100 words, how doing this course will enhance/change your practice?
2. This course will involve regular study, completion of assignments and patient evaluation, in addition to attending the two contact sessions. Do elaborate on how you would create sufficient time (2-3 hours in a week) for study, in addition to your current responsibilities.
3. Explain your commitment to work in the same hospital.

**PART – B**

**Hospital description**

1. Total Number of Beds: \_\_\_\_\_\_\_\_\_\_
2. Total Number of Departments: \_\_\_\_\_\_\_\_\_\_
3. Names of Departments:
4. Daily Average bed occupancy\_\_\_\_\_\_\_\_\_\_
5. Average Number of outpatients/day \_\_\_\_\_\_\_\_\_\_\_
6. Total Number of staff:

Doctors MBBS\_\_\_\_\_\_\_\_

 PG’s \_\_\_\_\_\_\_\_

Nurses Graduates\_\_\_\_\_\_\_\_

 Certificate\_\_\_\_\_\_\_\_

Lab technicians\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physiotherapists\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X-ray technicians\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselors/Social workers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacists \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Facilities available:

Radiology (list of tests available)

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6 \_\_\_\_\_\_\_\_\_\_\_\_\_

 Operation Theatre\_\_\_\_\_\_\_\_

 Labor room\_\_\_\_\_\_\_\_\_

Laboratory facilities (list of major test done)

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6 \_\_\_\_\_\_\_\_\_\_\_\_\_

Microbiology culture facility - Y/N

1. Do you have access to computers and internet? Yes\_\_\_\_\_\_ No\_\_\_\_\_

 **DECLARATION**

I declare that the information given in my application form and any additional information provided in support of my application is true and complete to the best of my knowledge and belief and also I am aware and understand that this is purely an institution run course and not affiliated to any University or National and International accreditation bodies.

 **Candidates Signature:**

**Name of the Candidate:**

**PART – C**

**SUPPORT FROM THE HOSPITAL**

How supportive would you be of the proposed course of the applicant? In what ways would you provide support the candidate? Please be specific as possible (time, recourses, administrative support and manpower)

Applicant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nominating Officer’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Nominating Officer’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POINTS TO NOTE:**

* The application form should be filled up legibly.
* Copies of MBBS and all other degree & registration certificates should be attached with the application. Incomplete applications will be disqualified.
* The candidates should bear their expenses for attending the contact programs towards travel, boarding and lodging.
* The last date for the receipt of completed application forms is 31st March 2023
* The short listed candidates shall be intimated in the month of April/May 2023 for interview
* The short listed candidates would be required to sign an undertaking that, they would comply with all the requirements of the course, before they are considered for the final selection.
* The organizers may hold an interview of short listed candidates.
* The conduct of the interview shall be at the sole discretion of the organizers.
* The course is likely to commence in July/August 2023

 **INSTRUCTION**

**All completed application forms need to be sent with the following documents:**

1. A copy of your resume / CV

2. Attested copies of the degree & registration certificates

3. Proof of paid application fee & please email the transaction details to fgid@cmcvellore.ac.in as well.

 All the stated documents need to be sent to:

**COURSE CONVENOR (FGID program)**

DEPT OF INFECTIOUS DISEASES

CHRISTIAN MEDICAL COLLEGE

SP COMPLEX 4TH FLOOR

IDA SCUDDER ROAD, VELLORE-632004,

TAMILNADU, INDIA

**OR**

Email it to fgid@cmcvellore.ac.in