Fellowship Center Enrollment Application/Preliminary Evaluation Form

1. General Details:

1	Name of the institute	
2	Address	
3	Phone and Fax	
4	E mail	
5.	Registration no of Hospital	
6	Year in which Hospital Established	
7	Year in which Level III NICU Established	
8.	Is Hospital/Institute recognized by MCI	
9.	Is Hospital recognized by National Board for DNB	
9	Is Hospital recognized for any other fellowship program, if yes please mention all	

2. Faculty/Consultant Neonatologist Details:

Attach Highest Qualification Certificate Copy and CV for each

S. No	Name	Qualification	Post Qualification Experience in years	IAP membership No and Neochap Membership No
1.				
2.				
3.				
4.				

No. of Senior Residents (Post MD/DCH):

Number of Junior Residents (Post MBBS):

Number of Staff Nurses in NICU:

3. Equipment Details :

S. No	Equipment	Number
1.	Radiant Warmer/ Incubator	
2.	Respiratory Support / Ventilator - HFO - Conventional - CPAP - HHFNC	
3.	Multipara Monitors (ECG/IBP/NIBP/Temp)	
4.	Pulse Oximeter	
5.	Phototherapy	
6.	Cooling Machine	
7.	Infusion Pumps	

4. NICU Admissions: Write last 5 years data in number per year

S. No	Data	Year………..	Year………	Year………	Year…….	Year……….
1.	NICU admissions					
2.	Ventilation					
3.	CPAP					
4.	No of Deliveries					

5. Facilities Available:

S. No	Facility	Yes/No
1.	Centralized Oxygen	
2.	Centralized Compressed Air	
3.	Centralized Suction	
4.	Portable X ray 24 hour	
5.	Lab Facility Including ABG 24 hour	
6.	Portable Ultrasound/ ECHO	
7.	ROP Screening and Treatment	
8.	Auditory Evaluation	
9.	High Risk Follow Up	
10.	Physiotherapy/ Occupational Therapy	
11.	Breast Feeding Training/Guidance	
12.	Kangaroo Mother Care	
13.	Ped Surgery	
14.	Lumbar Puncture	
15.	Exchange Transfusion	
16.	Intercostal Drainage	
17.	Peritoneal Dialysis	
18.	Blood Bank in the Institute	

6. Signatures:

Institute Head

Faculty 1

Faculty 2

Faculty 3

Faculty 4