

ADVANCED CERTIFICATE COURSE IN PREVENTION AND MANAGEMENT OF DIABETES & CARDIOVASCULAR DISEASE- CYCLE IV

(AUGUST 2019 - JANUARY 2020)

Participant Enrollment Form

*Name of Participant
(In Block Letter)

same will be printed on certificate

Father's Name

; YbXYf

Male

Female

PHOTOGRAPH

*Current Affiliation

Private Practice

Service

Central Govt

State Govt

If other, please specify

Medical College/Teaching Affiliation

Yes

No

If yes:

State
Govt.

Central
Govt.

Private

Location of practice

Rural

Urban

*Communication address

Place of work

Street

Nearest landmark

City

*District

State

*Pin code

STD code

Phone

If, same as above

Residence

Street

Nearest landmark

City

*District

State

*Pin code

STD code

Phone

Preferred mailing address

Place of work

Residence

Fax No

* Mobile No

Preferred contact number for communication

Preferred time for communication (between 9:00 AM to 5:00 PM)

*Email address

(In Block Letters)

Alternate Email address

(In Block Letters)

*Mandatory to be filled

***Date of Birth** D D M M Y Y Y Y **(Attach Proof)**

Type of registration **MCI** **State**

Specify your registration number

***Medical council registration number** **(Attach Proof)**

Date D D M M Y Y Y Y **State**

***Educational/Academic/Technical/Professional Qualification** (Attach Proof)

Qualification	College/Institution/Board/University	Dept	Year
MBBS			
MD			
MS			
DNB			
DM			
PhD			
DIP- CARD			
Any Other			

Total professional/clinical experience **Years**

Approximate number of patients treated per month

Out of all patients treated by you, how many are diagnosed with? **Diabetes** **CVD**

Details of Experience

Designation	Organization	From.....	To....

Any additional information (publication/presentation/awards/scientific scholarship if any)

Do you possess computer/laptop in your workplace or residence? Yes No

Do you have internet access to check emails regularly? Yes No

Please indicate motivation and benefits you foresee in undergoing this course.

DECLARATION

I hereby declare that the above mentioned information, which I have provided, is true to the best of my knowledge. I shall participate in the contact sessions organised once in a month on weekend and will devote self-reading time for the entire six modules and participate in the assessments, organised by the offering institution. I understand that by participating in this course, I am enhancing my knowledge and skills related to prevention and management of diabetes and cardiovascular disease and completion of the said course will not entitle me the status of any Endocrinologist/ Diabetologist or Cardiologist. I am aware of the fact that ACMDC is not a degree but only a certificate course with the objective to train doctors in the early diagnosis, prevention and management of cardiovascular complications of diabetes. I will not affix 'ACMDC' adjacent to my name or use it on any board/display. I also give my consent for publishing my feedback/testimonial which I forward to the Secretariat in any report or publication produced by PHFI. I also understand that this certificate course is not recognised Medical Qualification, under section 11 (1) of the Indian Medical Council Act 1956 and the Institution offering this course is neither a medical college or a university nor offering the course in accordance with the provisions of the Indian Medical Act of the University Grants Commission Act.

Signature

Date

Name

Place

RECOMMENDATION OF THE FACULTY (If required)

I hereby recommend Dr. _____ for the enrolment of **“Advanced Certificate Course in Prevention and Management of Diabetes & Cardiovascular Disease- Cycle IV”** to be conducted at my center starting in **August 2019**. I have verified all the relevant documents and s/he is eligible for the enrolment.

* Signature/E-mail Approval :

Date

Name of Faculty

Place

* In case of online application form, Kindly share email approval from the faculty

PAYMENT OPTIONS

NEFT Details:**Account Name:** Public Health Foundation of India**Bank Account:** HDFC Bank**Branch Address:** H7, Green Park Extn, Green Park, New Delhi-110016**Account Number:** 50100254381662**IFSC Code:** HDFC0000586**PAYMENT THROUGH DEMAND DRAFT**

Payment of ₹ 12,000/- should be in favour

PUBLIC HEALTH FOUNDATION OF INDIA

payable at New Delhi

OR**Check list of attachments with this application form (Please ✓ tick)**

1. Passport Size Photograph
2. Date of Birth Proof (High School Certificate/ PAN Card/ Passport/ Driving License)
3. MCI/ State Council Registration Certificate
4. MBBS Degree Certificate
5. DIP-CARD Certificate
6. MD, MS, DM, DNB, Ph. D – Degree (whichever is applicable, please attach all if applicable)
7. Any other additional certificate or fellowship in diabetes
8. Experience certificate

9. Mode of Payment: NEFT Demand Draft

NEFT Reference No./DD No

Date

DD MM YYYY

Name of Bank & Branch

***In case of online transaction, kindly send your filled application form
with reference number and supporting documents to
acmdc@phfi.org***

Please mail this form along with the required documents to:

Program Secretariat- ACMDC
Public Health Foundation of India
Plot No. 47, Sector - 44, Gurgaon, Haryana - 122002, India
Tel: +91 124 4781400, Extn: 4581, 4584
Email: acmdc@phfi.org
Web: www.phfi.org/ www.acmdc.org.in

