

CERTIFICATE COURSE IN CARDIOVASCULAR DISEASE AND STROKE (CCCS) CYCLE – II (FEBRUARY 2020 – JANUARY 2021)

Participant Enrolment Form

*Name of Participant

(In Block Letter)

same will be printed on certificate

Spouse / Father's
Name

Gender

Male

Female

*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

Residence, If, same as above

Street

Nearest landmark

City

*District

State

*Pin code

STD code

Phone

Preferred mailing address

Place of work

Residence

Fax No

*Mobile No

Preferred centre

*Preferred contact number for communication

Email address

Alternate Email address

Mandatory to be filled

*Date of birth D D M M Y Y Y Y

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

*Medical council registration number

*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			
Diploma			
Any other			

Total professional/clinical experience Years

Average number of patients treated per month

Details of Experience

Designation	Organization	From.....	To....
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How did you hear about the course?

Email	Conference	SMS
Journal	Friends/ Colleagues	Others, Please specify

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 Saturday/Sunday and will devote self-reading time for entire twelve modules and participate in the assessments, organised by the offering institution. 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 understand that CCCS is not a degree but only a certificate course with the objective of training doctors in prevention and management of cardiovascular disease and stroke. Successful participants are not entitled to mention/call themselves as Cardiologist anywhere after completion of this course. I also understand that this certificate course is not a 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

I hereby recommend Dr. _____ for the enrolment of
“CERTIFICATE COURSE IN CARDIOVASCULAR DISEASE AND STROKE, Cycle II” to be conducted at my center starting
 in **February 2020**. I have verified all the relevant documents and s/he is eligible for the enrolment. I also explained to the
 participant that CCCS is not a degree but only a certificate course with the objective of training doctors in prevention
 and management of cardiovascular disease. Successful participants are advised not to mention/call themselves as
cardiologist anywhere after completion of this course.

Signature/E-mail Approval :

Date

Name of Faculty

Place

PAYMENT OPTIONS

NEFT DETAIL (Rs. 20,000)

OR

PAYMENT THROUGH DEMAND DRAFT

Public Health Foundation of India

HDFC Bank Branch Address: H7, Green Park Extn, Green
 Park, New Delhi, Delhi 110016
 Account Number: 50100254381662
 IFSC Code: HDFC0000586

Course fees of **Rs. 20,000** in favour of
Public Health Foundation of India,
 payable at New Delhi

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. MD, MS, DM, DNB, Ph. D – Degree (whichever is applicable, please attach all if applicable)
6. Any other additional certificate or fellowship in cardiovascular disease
7. Experience certificate
8. 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 NEFT reference number and scanned supporting documents to cccs@phfi.org. Please note that there is no need to send hard copies of documents and application form in case of online transactions.

Please mail this form along with the original DD & required documents to:



Program Secretariat–CCCS

Public Health Foundation of India

Plot No. 47, Sector 44, Institutional Area, Gurgaon -122002, India

Tel: +91-124-4781400 Ext: 4575, 4584

Mobile: +91-9868090590, +91-8527578090 Fax: 0124-4722971

Email: cccs@phfi.org | Web: www.cccs.org.in, www.phfi.org



Strategic Partner

This course is endorsed by the Royal College
 of Physicians, London



**Royal College
 of Physicians**

Supported by an
 Educational Grant from

