महाराष्ट्र आरोग्य विज्ञान विद्यापीठ, नाशिक

Maharashtra University of Health Sciences, Nashik

दिंडोरी रोड, म्हसरुळ, नाशिक ४२२००४ Dindori Road, Mhasrul, Nashik 422004

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Local Inquiry Committee Inspection format for Continuation of Affiliation/Recognition For affiliated /or Training Center's conducting Fellowship/Certificate Course(s)

(As per provisions of the Maharashtra University of Health Sciences Act, 1998 and University Rule / Guidelines)

To,

The Registrar,
Maharashtra University of Health Sciences,
Vani – Dindori Road, Mhasrul,
Nashik 422 004

Sir,

I am/we are herewith submitting the Local Inquiry Committee Inspection format for Continuation of Affiliation/Recognition For affiliated Training Center`s conducting Fellowship/Certificate Course(s)

Sr. No.	Name of the Fellowship/Certificate Course	Course Started from the Academic Year	Intake Capacity Sanctioned by the University	No. of Student(s) Admitted (on the day of Inspection)
01	Minimal Access Surgery	2018	02	01
02	Colorectal Surgery	2018	02	00
03				
..				
..				

(Attach separate List if necessary)

- **Purpose of Present inspection:** (Tick whichever applicable and strike-out whichever not applicable)
  ~~Grant of Permission/ Recognition/ Increase of seats~~/Renewal of Affiliation/~~recognition/Compliance Verification~~
- **Date of last inspection of the department:** 01/06/2018
  (Write Not Applicable for first inspection)
- **Purpose of Last Inspection:** Recognition / Affiliation
- **Result of last Inspection:** Approved
  (Copy of University Letter to be attached)
- **Fellowship/Certificate Course Co-ordinator Details:**
  Name: Dr. Zoeb Haider
  Mobile/Telephone no.: 9921664629
  e-mail id: Zoebhaider@gmail.com

PART – I

(INSTITUTIONAL INFORMATION)

(to be filled by the concerned Training Center & cross verified by the Local Inquiry Committee)

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

Name: Dr. Vikram Desai Age: 55 *(Date of Birth)* 28/12/1965

	Subject	Year	Institution	University
PG Degree	M.S.	1989	GMC, Nagpur	MAGPUR University
Recognized / Not Recognized				

Teaching Experience

Designation	Institution	From	To	Total Exp.
Asst. Professor	Indira Gandhi medical college	01.2.1992	16.03.99	07
Asso. Professor/Reader	Indira Gandhi medical college	17.3.1999	01/2/05	06
Professor	Index Medical College Indore	26.03.07	30.6.8	05
Any Other		Gran d Total		

2. **Management/Society/Inst. Information :**

01	**i) Name of the Society/Institution/ College/University Department:**	SEVENSTAR HOSPITAL, A Unit of Nagpur Institute of Surgical Sciences & Research Centre
	ii) Postal Address, with PIN:	324/01 Jagnade Square, Nagpur 09 Tele:
	iii) Contact Details:	Mob: 8983144466 ,
02	**Society/Institution/College Registration Number and date:**	i) Public Trust Act 1950: .....
		ii)Society's Registration Act.1860: .....
		iii) Year of establishment:
		iv) Copies of Registration, Constitution and Memorandum of Association attached? *Yes/No– Yes Marked as Appendix 'A'
03	**Hospital Information :** ***(It is mandatory for Training Centre/applying Institute to have their own functional Hospital as per norms)*** i) Name of the Hospital ii) Nursing Home Registration No. iii) Establishment Year	SevenStar Hospital ..... 992 ..... 2017 ..... – Mark as Appendix 'B'
04	**i) Name of the College/Institute where course is to be conducted:**	SevenStar Hospital, A Unit of Nagpur Institute of Surgical Sciences & Research Centre Pvt Ltd.
	ii) Postal Address, with PIN: iii) Contact Details: iv) E-mail ID:	324/01 Jagnade Sq. Nagpur Mob: 8983144466 Tele: 0712-6699211 info@sevenstarhospitals.com
	v) List of University approved Fellowship/Certificate Course(s) **conducted / already running** at Training Centre with Intake Capacity	**Name of the Course(s) ..... Approved Intake Capacity... ... ... Affiliated Since... ... (if necessary Attach separate List)** Fellowship in minimal Access Surgery, Fellowship in Colorectal Surgery
	vi) Training Centre / Institute **willing/desirous to Start/Open** Fellowship/Certificate Course(s) (For New Opening Purpose only)	**Name of the Course(s)** ..... **Required Intake Capacity...** 02 **(if necessary Attach separate List)**
05	Affiliation Fees details: (Bank/DD no./ date/amount/ NEFT/RTGS)	Paid Fees details Attached : *Yes/No. (Pending Fees, if any:)
06	Financial position of the Society/ Institute in the preceding 03 years:	Audited Statements of Accounts for Yes *Yes/No– Mark as Appendix 'C'
07	Budgetary provision for the FC/CC/DC for the next 03 years	19-20-621 lacs 20-22- 714 lacs i) 2023-24 Rs. 8.18 Lacs
08	Management Resolution seeking Recognition of Institute for FC/CC/DC of MUHS, Nashik:	Resolution No. ..... dated ..... Copy of Management Resolution attached? *Yes/No– Mark as Appendix 'D'

PART – II
(HOSPITAL INFORMATION)

(Information to be filled by the concerned Training Center & cross verified by the Local Inquiry Committee)

1. **Name of the Hospital:** Seven Star Hospital a unit of Nagpur Institute of Surgical Sciences & Research Centre Pvt Ltd

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	47452	OPD	7050
IPD (Total No. of Patients admitted)	6055	IPD (Total No. of Patients admitted)	1700

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

In the entire hospital	
No of Beds	105
No of Beds in ICU	15
No of Beds in IRCU	-
No of Beds in SICU	18
No of Major O.T.	07
No of Minor O.T.	03

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

	On Inspection day	Average of random 3 days
◦ No. of available for clinical service on inspection day:		
◦ Daily OPD – 2 PM	52	50-60
◦ Daily admissions	18	20-30
◦ Daily admissions in Dept. Through casualty at 10am	08	10-12
◦ Bed occupancy in the Dept. at 10AM	74%	70%
◦ Number of patients in ward (IPD)	82	100
◦ Percentage bed occupancy at 10Am	64%	86%

◦ 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	Aver age of random 3 days
◦	.....	.....
◦ Attached	.....	.....
◦	.....	.....
◦	.....	.....
◦	.....	.....

09	**Other Information:**	
	a) Land:	*Yes/No. If yes, then Area: ... 3106.172 Sq.m
	i) Whether the land is owned by the Applicant Institute/College/ 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: ..... dated .... at (Place): ..... Copy of Land Registration Certificate attached? *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 ..... Copy of Loan/Mortgage Deed attached? *Yes/No. – Mark as Appendix 'G'
	b) Building: i) Total built-up area:	..... ~~sq. ft.~~ 27593.689 Sq.ft Certified copy of Building Plan attached? *Yes/No – Mark as Appendix 'H'

3. **Central Library**

- Total number of Books in library: 500
- Books pertaining to concerned Fellowship subject: 200
- Purchase of latest editions of concerned books in last 3 years: - Yes

- Journals:

	Journals		Total	concerned Fellowship subject
	Indian		03	
	Foreign			

- Year / Month up to which latest Indian Journals available: April-2017
- Year / Month up to which latest Foreign Journals available:
- Internet / Med pub / Photocopy facility: available / not available
- Library opening times: 24hrs
- Reading facility out of routine library hours: available / not available

(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		03	03			
No. of Students		06	06			
Status of Cleanliness		Yes	Yes			

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

5. **Casualty:/ Emergency Department :**

Space	40 Sq Mt
Number of Beds	07
No. of cases (Average daily OPD and Admissions):	20
Emergency Lab in Casualty (round the clock):	available / not available
Emergency OT and Dressing Room	Available
Staff (Medical/Paramedical)	11
Equipment available	11

6. **Blood Bank :** Applied (Blood Storage Centre

(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	FFP-07 Nos 37	
(vi)	Average blood units consumed daily and on inspection day in the entire Hospital (give distribution in various specialties)	Average daily 03	On Inspection day 05

7. **Central Laboratory:**
   - Controlling Department: Pathology
   - No of Staff : 15
   - Equipment Available : Attach separate List Attached
   - 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~~

(1) **Sign & Stamp**
Head of the Department
Date:

SEVEN STAR HOSPITAL
A UNIT OF
NAGPUR INSTITUTE SURGICAL SCIENCE & RESEARCH CENTRE PVT. LTD.

(2) **Sign & Stamp**
Dean/Principal/Head of Institute
Date:

DR. PRASHANT RAHATE
M.S., MS (General Surgery)
Reg. No. MMC 62903

College/Institute Round Seal

SEVEN STAR HOSPITAL NAGPUR INSTITUTE OF SURGICAL SCIENCE & RESEARCH CENTRE PVT. LTD. NAGPUR

PART – III

(DEPARTMENTAL INFORMATION)

(Information to be filled by the concerned Training Center & cross verified by the Local Inquiry Committee)

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

1. **Fellowship Specialty Department to be inspected** :Surgery
2. **Date on which independent department of functioning concerned specialty was created and started** :21/09/17

3. **Mentor's details (From start of department till date) :**

Sr. No.	Name	Full Time/ Part Time	Designation	Qualification	Experience in Yrs. (after acquiring PG Qualification in concerned Subject)
1)	Dr. Vikram Desai	FT	Dean	M.S.	14 Yrs
2)	Dr. Prashant Rahate	FT	Director	M.S.	10 Yrs
	Dr. Zeeba Haider	FT	"	"	03 Yrs

4. **Whether Independent Department of concerned Fellowship subject exists in the Institution :**
   Yes/No: ..... Since when: Nov 2017

5. **Specialty Department Infrastructure Details :**

Facility	Area (sft.)	Available	Not Available
Faculty rooms	300 Sq.ft	✓	
Clinics	180 Sq ft	✓	
Laboratory Space	550 Sq.ft	✓	
Seminar room	250 Sq.ft.	✓	
Department Library	200 Sq.ft	✓	
PG common room	200 Sq.ft	✓	
Pre clinical lab (where ever applicable)		X	✓
Patient waiting room	4000 Sq.ft	✓	
Total area			

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. (give names)
2018	Minimal Access Surgery	01	01 (Dr. P. Rahate)

(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:** Attached

Sr.No.	Name	Designation

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) ~~Attd~~

Sr. No.	Name of the Equipment	Specification	Functional / Not Functional	Qty.
1)	DA Vinci Robot	Standard	Functional	1
2)	Endoscopic machine	Olympus	Functional	1
3)	Blue light endoscope	LEC910	Functional	1

9. **Intensive care Service provided by the Department:** (Emergency) Yes

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
1)	Colorectal Surgery	Mon-wed-fri	4pm-6pm	50-60	Dr Rahate Dr Haider
2)	Laparoscopic Surg.	—11—	—11—	30-35	Dr. Rahate, Dr. Haider

11. **Services provided by theDepartment:**

a) Services

i. Out Patient Services

ii. Inpatient Services

iii. Operation theatre

(b) Ancillary Services— Diagnostic, Pharmacy, Ambulance Radiology, Emergency.

(f) Others: _____

12. **Space:**

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

13. **Office space:**

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

14. **Clinical Load of Dept.** : **No of Surgeries / Procedures** 15-20 **Per day**

15. **Submission of data to National Authorities if any :** ~~##~~ Yes

16. **Overall Impression:** *(To be filled by the Local Inquiry Committee)*

Particular	Deficient	Satisfactory
Infrastructure		✓
Clinical Material		✓
Staff Assessment		✓
Student Assessment		✓
Library facilities		✓
Equipment		✓
Overall Department Assessment		✓

17. **Any Other Observations & Overall Remarks of The Local Inquiry Committee** (Not More Than 3 Lines): *(To be filled by the Local Inquiry Committee)*

Sr. No.	Particular	-	
01.	Recommendation for Recognition of the Institute (If applicable)	:	
02.	Recommendation for Starting New Fellowship / Certificate Courses (If applicable)	:	
03.	Recommendation for Existing Fellowship/ Certificate Courses For Continuation of Recognition/ Affiliation (If applicable)	:	Recommended
04.	Recommendation for Increase in Intake of Fellowship / Certificate Courses (If applicable)	:	

	Name of the LIC Chairman/Members	Signature
01	DR. Raj Gajbhiye	
02		
03		

Annexure – I

Information to be filled by the each Mentor,
It shall be verified by the Head of the concerned Training Center,
Subsequently endorsed by Local Inspection Committee at the time of visitation.

Sr. No.	Particular	-	Information to be filled
01.	Name of the Mentor	:	Dr. Vikram Desai
02.	Date of Birth	:	28th Dec 1963
03.	Address	:	Desai Hospital & Research Centre, Ramkrishna Nagar, Khamla - 440015
04.	Tel. No./ Mob. No.	:	9823023272
05.	e-mail id	:	vdesai@yahoo.com.
06.	Nationality	:	Indian
07.	Qualification in details : (attach documentary proof)	:	MBBS, M.S.
08.	Teaching experience / Health Sciences: Profession experience /Consultant/Mentor (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)	:	**A) General Experience:**

Designation	From	To	Total Period (Yrs. & Months)
Professor	7/13	19 01/2/19	5Yrs 7Yrs 01Yrs
Asst Prof			
Prectr			

B) Experience in the Subject of concerned Fellowship/Certificate Course: same as above

Designation	From	To	Total Period (Yrs. & Months)

09.	Present Appointment	:	Yes
10.	Publications (Lis t & Proof)	:	
11.	Post Graduate Teaching experience (Attach documentary evidence)	:	15 Yrs
12.	Any other relevant information	:	

Date :-

Name & Sign. of Mentor

SEVEN STAR HOSPITAL A UNIT OF NAGPUR INSTITUTE SURGICAL SCIENCE & RESEARCH CENTRE PVT. LTD.

For the use of affiliated Training Center:

On the basis of experience certificates and documents submitted by the concerned Mentor, 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).

Sign of Head of the Department
(HOD of concerned Department of Fellowship Subject, if any ;)
Date:

SEVEN STAR HOSPITAL NAGPUR INSTITUTE SURGICAL SCIENCE & RESEARCH CENTRE PVT. LTD.

Sign & Stamp of Head of the Training Center
(Director / Dean / Principal of the Training Center/ Chief Hospital/College/Health Center)
Date:

Dr. PRASHANT BARATE
MBBS, MS (Gen.), Fellow in Surgery
Reg. No. MMC 62903

SEVEN STAR HOSPITAL A UNIT OF NAGPUR INSTITUTE SURGICAL SCIENCE & RESEARCH CENTRE PVT. LTD. NAGPUR

For the use of LIC Chairman/Member:

Above candidate is Recommended /Not Recommended for Mentor
(Tick whichever applicable and strike-out whichever not applicable)

Name & signature with date of LIC Chairman/Member

Chairman: .....
Date : 17/10/19

Member : .....
Date :

Annexure – I

Information to be filled by the each Mentor,
It shall be verified by the Head of the concerned Training Center,
Subsequently endorsed by Local Inspection Committee at the time of visitation.

Sr. No.	Particular	-	Information to be filled
01.	Name of the Mentor	:	Dr. Prashant Rahate
02.	Date of Birth	:	13th feb 1985
03.	Address	:	Jagnade square, Nagpur
04.	Tel. No./ Mob. No.	:	9822464068
05.	e-mail id	:	prashantrahate84@yahoo.com
06.	Nationality	:	Indian
07.	Qualification in details : (attach documentary proof)	:	MBBS M/S. AMASI
08.	Teaching experience / Health Sciences: Profession experience /Consultant/Mentor (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)	:	**A) General Experience:**

Designation	From	To	Total Period (Yrs. & Months)
Registrar	1990	1992	2 yrs

B) Experience in the Subject of concerned Fellowship/Certificate Course:

Designation	From	To	Total Period (Yrs. & Months)

09.	Present Appointment	:	DIRECTOR, SEVENSTAR HOSPITAL
10.	Publications (List & Proof)	:	
11.	Post Graduate Teaching experience (Attach documentary evidence)	:	
12.	Any other relevant information	:	

Date :-

Dr. PRASHANT RAHATE
MBBS, MS (General Surgery)
Reg. No. MMC 62963

Name & Sign of Mentor

For the use of affiliated Training Center:

On the basis of experience certificates and documents submitted by the concerned Mentor, 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).

Sign of Head of the Department
(HOD of concerned Department of Fellowship Subject, if any :)
Date:

SEVENSTAR HOSPITAL
A UNIT OF
NAGPUR INSTITUTE SURGICAL SCIENCE & RESEARCH CENTRE PVT. LTD.

Sign & Stamp of Head of the Training Center
(Director / Dean/Principal of the Training Center/ Institute/Hospital/College/Health Center)
Date:

Dr. PRASHANT RAHATE
MBBS, MS (General Surgery)
Reg. No. MMC 62963

SEVENSTAR HOSPITAL
A UNIT OF
NAGPUR INSTITUTE OF SURGICAL SCIENCE & RESEARCH CENTRE PVT. LTD.
NAGPUR

For the use of LIC Chairman/Member:

Above candidate is Recommended /Not Recommended for Mentor
(Tick whichever applicable and strike-out whichever not applicable)

Name & signature with date of LIC Chairman/Member

Chairman: .....
Date : 17/10/19

Member : .....
Date :

Annexure – I

Information to be filled by the each Mentor,
It shall be verified by the Head of the concerned Training Center,
Subsequently endorsed by Local Inspection Committee at the time of visitation.

Sr. No.	Particular	-	Information to be filled
01.	Name of the Mentor	:	DR. ZOEB HAIDER
02.	Date of Birth	:	04 Oct 1963
03.	Address	:	Jagmade Square, Nagpur
04.	Tel. No./ Mob. No.	:	9921664629
05.	e-mail id	:	zoebhaider@gmail.com
06.	Nationality	:	Indian
07.	Qualification in details : (attach documentary proof)	:	MBBS, M.S. FRCS
08.	Teaching experience / Health Sciences: Profession experience /Consultant/Mentor (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)	:	**A) General Experience:** Designation | From | To | Total Period (Yrs. & Months) Lecturer | 2005 | 2011 | 6 yrs **B) Experience in the Subject of concerned Fellowship/Certificate Course:** same as above Designation | From | To | Total Period (Yrs. & Months)
09.	Present Appointment	:	Director, Revenstar Hospital, Nagpur
10.	Publications (List & Proof)	:	
11.	Post Graduate Teaching experience (Attach documentary evidence)	:	
12.	Any other relevant information	:	

Dr. ZOEB HAIDER
MBBS, MS, FRCS
Reg. No. MMC57768

Date :- **Name & Signature of Mentor**

For the use of affiliated Training Center:

On the basis of experience certificates and documents submitted by the concerned Mentor, 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).

Sign of Head of the Department
(HOD of concerned Department of Fellowship Subject, if any :)
Date:

Sign & Stamp of Head of the Training Center
(Director / Dean/Principal of the Training Center/ Institute/Hospital/College/Health Center)
Date:

REVENSTAR HOSPITAL A UNIT OF NAGPUR INSTITUTE OF SURGICAL SCIENCE & RESEARCH CENTRE PVT. LTD. NAGPUR

For the use of LIC Chairman/Member:

Above candidate is Recommended /Not Recommended for Mentor
(Tick whichever applicable and strike-out whichever not applicable)

Name & signature with date of LIC Chairman/Member

Chairman: .....
Date : 17/10/19

Member : .....
Date :