



# महाराष्ट्र आरोग्य विज्ञान विद्यापीठ, नाशिक

Maharashtra University of Health Sciences, Nashik  
दिंडोरी रोड, म्हासरुळ, 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	62	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

PG Degree	Subject	Year	Institution	University
Recognized / Not Recognized	M.S.	1989	Gmc, Nagpur	MADUR University Institute

**Teaching Experience**

Designation	Institution	From	To	Total Exp.
Asst. Professor	Indira Gandhi Medical College	01.2.1992	11.03.99	07
Asso. Professor/Reader	Indira Gandhi Medical College	17.3.1999	01/2/05	06
Professor	Indira Gandhi Medical College	26.03.07	20.6.8	03
Any Other		Grand 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, Indira Gandhi Square, Nagpur 462009
	iii) Contact Details:	Mob: 8983144666, Tele: 2712-669811
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 )	..... Sevenstar Hospital.....
		i) Name of the Hospital
		..... 992 .....
		ii) Nursing Home Registration No.
..... 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
		ii) Postal Address, with PIN:
		iii) Contact Details:
		iv) E-mail ID:
	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)
vi) Training Centre / Institute willing/desirous to Start/Open Fellowship/Certificate Course(s) (For New Opening Purpose only)	Name of the Course(s) .....	
	Intake Capacity... .. (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/No- Mark as Appendix 'C'
07	Budgetary provision for the FC/CC/DC for the next 03 years	19-20-62 Lakhs, 20-21-714 Lakhs
		i) 2023-24 Rs. 8.10 Lakhs
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)*

- Name of the Hospital: Sevenstar Hospital - A Unit of Nagpur Institute of Surgical Sciences & Research Centre Pvt. Ltd.
- 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)**

- No. of available for clinical service on inspection day:

	On Inspection day	Average of random 3 days
• Daily OPD - 2 PM	52	50-60
• Daily admissions	18	20-30
• Daily admissions in Dept. Through casualty at 10am	10	10-12
• Bed occupancy in the Dept. at 10AM	77%	70%
• Number of patients in ward (IPD)	82	100
• Percentage bed occupancy at 10Am	84%	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*

<b>Other Information:</b>		
a) Land:		*Yes/No. If yes, then Area: ... <u>3106:172 sq.m</u>
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'
09 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:		..... sq-ft. <u>27593.689 sq.ft</u>
i) Total built-up area:		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: - 70

• Journals:

	Journals	Total	concerned Fellowship subject
	Indian	<u>03</u>	
	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: 2 hrs
- 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		<u>03</u>	<u>03</u>			
No. of Students		<u>06</u>	<u>06</u>			
Status of Cleanliness		<u>Yes</u>	<u>Yes</u>			

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 center

(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	PPP - 27	
(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 [Signature]  
Sign & Stamp  
Head of the Department

NAGPUR  
Date: \_\_\_\_\_  
INSTITUTE SURGICAL SCIENCE &  
RESEARCH CENTRE PVT. LTD.

② [Signature]  
Sign & Stamp  
Dean/Principal / Head of Institute  
Date: \_\_\_\_\_  
PRASHANT RAHATE  
M.S (General Surgery)  
Reg. No. MMC 62903



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.	16 Yrs
2)	Dr. Prashant-Rahale	FT	Director	M.S.	16 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. Rahale)

(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) Att

Sr. No.	Name of the Equipment	Specification	Functional / Not Functional	Qty.
1)	DA Vinci Robot	Stacel. Ast	functional	1
2)	Endo-SP machine	olympus	functional	1
3)	Blue light endoscope	Legevic	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	non-regular	as required	50-60	Dr. Roshale, Dr. Haider
2)	Laparoscopic Surg.	-1-	-1-	30-35	Dr. Roshale, Dr. Haider

11. Services provided by the Department:

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)	: <u>Recommended</u> _____ _____
04.	Recommendation for Increase in Intake of Fellowship / Certificate Courses (If applicable)	: _____ _____ _____

	Name of the LIC Chairman/Members	Signature
01	<u>Dr. Raj Gajbiye</u>	<u>[Signature]</u>
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, 49037, Ranakrishna nag, Khambha	
04.	Tel. No./ Mob. No.	:	9823023272	
05.	e-mail id	:	vdesai@preled.com	
06.	Nationality	:	Indian	
07.	Qualification in details : (attach documentary proof)	:	M.B.B.S., 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	7/10/19 01/2/0	5yrs
		Asst. Prof		7yrs
		Asst. Lect		01yrs
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 (List & Proof)	:		
11.	Post Graduate Teaching experience (Attach documentary evidence)	:	15 yrs	
12.	Any other relevant information	:		

Date :-

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. 05/2917 (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, District Hospital of the Training Center/ M.B.B.S. & M.S. (General Surgery) Faculty Center):

Date: \_\_\_\_\_  
Reg. No. MMC 62903

**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.J.S. AMMASI
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)
		Registered	1990 1992 2yrs
		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. MNC 62963

*prahate*

**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:



**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

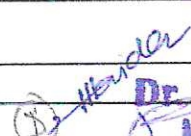
Chairman: *[Signature]*  
Date: 17/10/19

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 1983		
03.	Address	:	Jagnade 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)	:	MBS, MS, 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	5 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, Govt. Hospital, Nagpur		
10.	Publications (List & Proof)	:			
11.	Post Graduate Teaching experience	:			
	(Attach documentary evidence)	:			
12.	Any other relevant information	:			

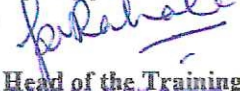
  
**Dr. ZOEB HAIDER**  
 MBBS, MS, FRCS  
 Name & Stamp of Mentor: **MG57768**

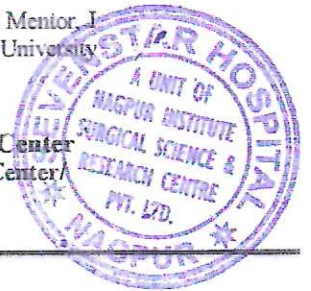
Date :-

**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:

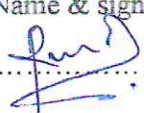
  
 Sign & Stamp of Head of the Training Center  
 (Director / Dean / Principal of the Training Center)  
 Institute / Hospital / College / Health Center)  
 Date:



**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: .....