



# महाराष्ट्र आरोग्य विज्ञान विद्यापीठ, नाशिक

Maharashtra University of Health Sciences, Nashik  
दिंदोरी रोड, म्हासळ, नाशिक ४२२००४ Dindori Road, Mhasrul, Nashik 422004  
Tel : (0253) 2539244/241/156. Fax : (0253) 2539242

[www.muhs.ac.in](http://www.muhs.ac.in), [fccc@muhs.ac.in](mailto:fccc@muhs.ac.in)

## 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:** 17/10/2019  
(Write Not Applicable for first inspection)
  - **Purpose of Last Inspection:** Affiliation Continuation
  - **Result of last Inspection:** Approved.  
(Copy of University Letter to be attached)
  - **Fellowship/Certificate Course Co-ordinator Details:**  
Name: Dr. Zaeb Haiden
- Mobile/Telephone no.: 9921664629  
e-mail id: zoebhaiden@gmail.com

**PART - I**  
**(INSTITUTIONAL INFORMATION)**

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

Name: Dr. Vikram Desai Age: 57 (Date of Birth) 28/12/1963

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

**Teaching Experience**

Designation	Institution	From	To	Total Exp.
Asst. Professor	Indira Gandhi Medical	01.2.1992	16.02.99	07
Asso. Professor/Reader	Indira Gandhi Medical	17.3.1999	01/12/05	06
Professor	Index Medical College	26.03.07	30.11	
Any Other	Indore		Grand Total	

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

01	i) Name of the Society/Institution/ College/University Department:	SEVENSTAR HOSPITAL, A UNIT at NAGPUR Institute of Surgical Sciences & Research Centre Pvt Ltd.	
	ii) Postal Address, with PIN:	324101 Jagade Square, Nagpur 09.	
	iii) Contact Details:	Mob: 8983114466. Tele:	
	iv) E-mail ID:		
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- Mark as Appendix 'A'	Yes
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	Sevenstar Hospital
		ii) Nursing Home Registration No.	992
		iii) Establishment Year	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 & Res Centre. Pvt. Ltd.	
		ii) Postal Address, with PIN:	324101 Jagade Square Nagpur
		iii) Contact Details:	Mob: 8983114466 Tele: 0712-6699811
		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) .....	1) Fellowship in Minimal Access Surgery. 2) Fellowship Colorectal Surgery.	
	Required Intake Capacity... .. (if necessary Attach separate List)	02	
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' Yes	
07	Budgetary provision for the FC/CC/DC for the next 03 years	20-21 - 75 lakh, 21-22 - 85 lakh i) 2022-23 Rs. 95 lakh.	
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'	

Other Information:	
a) Land:	
i) Whether the land is owned by the Applicant Institute/College/ Trust:	*Yes/No. If yes, then Area: <u>3106.172 sq. mt.</u>
ii) Whether the land is registered?	Copy of land documents i.e. 7/12 extract, Property Card, etc. attached? *Yes/No - <u>Mark as Appendix 'E'</u>
	*Yes/No. If yes, Registration Number: ..... dated ..... at (Place): .....
09 iii) Any loans, mortgage, etc. shown against the title of the land:	Copy of Land Registration Certificate attached? *Yes/No. - <u>Mark as Appendix 'F'</u>
	*Yes/No. If yes, amount of loan Rs. /mortgaged for Rs .....
b) Building:	Copy of Loan/Mortgage Deed attached? *Yes/No. - <u>Mark as Appendix 'G'</u>
i) Total built-up area:	..... sq. ft. <u>27993.489 sq. ft.</u>
	Certified copy of Building Plan attached? *Yes/No
	- <u>Mark as Appendix 'H'</u>

3.

**Central Library**

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

670  
290  
400

Journals	Total	concerned Fellowship subject
Indian	<u>05</u>	
Foreign		

- Year / Month up to which latest Indian Journals available:
  - Year / Month up to which latest Foreign Journals available:
  - Internet / Med pub / Photocopy facility:
  - Library opening times:
  - Reading facility out of routine library hours:
- (Obtain list of books & journals duly signed by Dean)

available / not available  
12 hours?  
available / not available

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						
No. of Students						
Status of Cleanliness						

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

**PART - II**

**(HOSPITAL INFORMATION)**

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	57427	OPD	
IPD (Total No. of Patients admitted)	7689.	IPD (Total No. of Patients admitted)	

**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	.....	.....
• Daily admissions	.....	.....
• Daily admissions in Dept. Through casualty at 10am	.....	.....
• Bed occupancy in the Dept. at 10AM	.....	.....
• Number of patients in ward (IPD)	.....	.....
• Percentage bed occupancy at 10Am	.....	.....
- 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
• .....	.....	.....
• .....	.....	.....
• .....	.....	.....
• .....	.....	.....

5. Casualty:/ Emergency Department :

Space	
Number of Beds	40 sq. mt
No. of cases (Average daily OPD and Admissions):	0-7
Emergency Lab in Casualty (round the clock):	20
Emergency OT and Dressing Room	available / not available
Staff (Medical/Paramedical)	Available
Equipment available	Available

6. Blood Bank : 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	✓ Yes / No	
(vi)	Average blood units consumed daily and on inspection day in the entire Hospital ( give distribution in various specialties)	Average daily 09	On Inspection day

7. Central Laboratory:

- Controlling Department: Pathology
- No of Staff : 10
- Equipment Available : Attach separate List Attached
- Working Hours: 24 hours

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:

- ICD X classification

Computerized / ~~Non computerized~~  
Used / Not used

Sign & Stamp

Head of the Department

SEVENSTAR HOSPITAL

A UNIT OF

NAGPUR INSTITUTE SURGICAL SCIENCE & RESEARCH CENTRE PVT. LTD.

College/Institute Round Seal

Sign & Stamp

Dean/Principal/Head

Date:

Prashant Rahate

DR. PRASHANT RAHATE

M.B.B.S, M.S. (General Surgery)

Reg. No. MMC 62903

**PART - III**  
**(To be filled by the Local Inquiry Committee)**

**(DEPARTMENTAL INFORMATION)**

(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 created and started 21.09.17 : functioning concerned specialty was

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	MS	16 yrs.
2	Dr. Praphant Rahate Dr. Zaeb Haiden	FT	Director Director	MS MS	10 yrs. 05 yrs.

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

5. Specialty Department Infrastructure Details :

Facility	Area (sft.)	Available	Not Available
Faculty rooms	300 Sq. ft.	✓	
Clinics	180 Sq. ft.	✓	
Laboratory Space	5550 Sq. ft.	✓	
Seminar room	280 Sq. ft.	✓	
Department Library	200 Sq. ft.	✓	
PG common room	200 Sq. ft.	✓	
Pre clinical lab (where ever applicable)		✓	
Patient waiting room	4000 Sq. ft.	X	✓
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	0	
2020	Minimal access surgery		

( 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:

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)

Sr. No.	Name of the Equipment	Specification	Functional / Not Functional	Qty.
1	DA VINCI ROBOT	state of the Art	Functional	1
2	Endoscopy machine	Olympus	Functional	1
3	Blue light Endoscope	Leobio	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	9am-4pm	50-60	Dr. Rahate, Dr. Haider
2)	Laparoscopic Surgery	- 11 -	- 11 -	30-35	Dr. Rahate, Dr. Haider

11. Services provided by the Department:

a) Services

i. out patient Services

ii. Inpatient Services

iii. Operative 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	<u>Yes</u>	<u>Yes</u>
2	Equipment's	<u>Yes</u>	<u>Yes</u>
3	Teaching Space	<u>Yes</u>	<u>Yes</u>
4	Waiting area for patients	<u>Yes</u>	<u>Yes</u>

13. Office space:

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

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

	Name of the LIC Chairman/Members	Signature
01		
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 37 Ramkrishna Nagar, Khami 440 015			
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)	:	<b>A) General Experience:</b>			
			Designation	From	To	Total Period (Yrs. & Months)
			Professor.			5 Yrs.
			Lecturer.			01 Yr.
			<b>B) Experience in the Subject of concerned Fellowship/Certificate Course:</b>			
			Designation	From	To	Total Period (Yrs. & Months)
09.	Present Appointment	:	Yes			
10.	Publications (List & Proof)	:				
11.	Post Graduate Teaching experience	:	15 yrs			
	(Attach documentary evidence)					
12.	Any other relevant information	:				

Date :-

**SEVENSTAR HOSPITAL**

Name & Unit of Mentor

**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).

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

Sign & Stamp of Head of the Training Center  
**DR. PRASHANT RAHATE**  
(Director / Dean/Principal of the Training Center/  
Institute/Hospital/College/Health 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 :

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 1965																																				
03.	Address	: Sagnade Squire, 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, MS. AAMASI																																				
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)	: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4">A) General Experience:</th> </tr> <tr> <th>Designation</th> <th>From</th> <th>To</th> <th>Total Period (Yrs. &amp; Months)</th> </tr> </thead> <tbody> <tr> <td>Registrar</td> <td>1990</td> <td>1992</td> <td>2 years</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td colspan="4">B) Experience in the Subject of concerned Fellowship/Certificate Course:</td> </tr> <tr> <th>Designation</th> <th>From</th> <th>To</th> <th>Total Period (Yrs. &amp; Months)</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	A) General Experience:				Designation	From	To	Total Period (Yrs. & Months)	Registrar	1990	1992	2 years					B) Experience in the Subject of concerned Fellowship/Certificate Course:				Designation	From	To	Total Period (Yrs. & Months)												
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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**  
Name & Signature of Mentor  
**MBBS, MS (General Surgery)**  
Reg. No. MMC 62903

**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).

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

**Dr. PRASHANT RAHATE**  
Sign & Stamp of Head of the Training Center  
(Director / Dean/Principal of the Training Center/  
Institute/Hospital/College/Health Center)  
**MBBS, MS (General Surgery)**  
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 :

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	: Jagade 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, 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)	: <table border="1"> <thead> <tr> <th colspan="4">A) General Experience:</th> </tr> <tr> <th>Designation</th> <th>From</th> <th>To</th> <th>Total Period (Yrs. &amp; Months)</th> </tr> </thead> <tbody> <tr> <td>Lecturer</td> <td>2005</td> <td>2011</td> <td>6 yrs</td> </tr> <tr> <td colspan="4">B) Experience in the Subject of concerned Fellowship/Certificate Course: Same as above</td> </tr> <tr> <th>Designation</th> <th>From</th> <th>To</th> <th>Total Period (Yrs. &amp; Months)</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	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)								
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Designation	From	To	Total Period (Yrs. & Months)																											
09.	Present Appointment	: Director, Sevenstar Hospital, Nagpur																												
10.	Publications (List & Proof)	: <i>Haider</i>																												
11.	Post Graduate Teaching experience (Attach documentary evidence)	: <i>Haider</i>																												
12.	Any other relevant information	: <i>Haider</i>																												

Date :-

**Dr. ZOEB HAIDER**  
Name & Signature of Mentor  
Reg. No. MMC57768

**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).

**SEVENSTAR HOSPITAL**  
(HOD of concerned Department of Fellowship Subject, if any.)  
**NAGPUR INSTITUTE SURGICAL SCIENCE & RESEARCH CENTRE PVT LTD**

*P. Rahate*  
**Dr. PRASHANT RAHATE**  
(Director / Dean/Principal of the Training Center/ Institute/Hospital/College/Health Center)  
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 :

Member : .....  
Date :