CCCA/

PUBLIC HEALTH FOUNDATION OF INDIA

CRF

Narayana Health™
Health for all. All for health.

CERTIFICATE COURSE IN MANAGEMENT OF COPD & ASTHMA CYCLE-I

(NOV 2016 - JUNE 2017)

Participant Enrolment Form

***Name** (In Block Letters) D R .

(Same will be printed on the certificate, If Eligible)

Father's/ Husband's Name

Paste (not Staple) your latest passport size colour photograph

Gender ☐ Male ☐ Female

***Current Affiliation:** ☐ Private { ☐ Pvt. Service ☐ Practice } ☐ Govt. { ☐ Central Govt. ☐ State Govt. } ☐ Others

if other, please specify.....

Medical College/Teaching Affiliation: ☐ Yes ☐ No *If Yes:* ☐ State Govt. ☐ Central Govt. ☐ Private

Communication Address

- **Place of work**

Street

Nearest Landmark

City District

State *Pin

STD Code Phone No

- **Residence**

Street

Nearest Landmark

City District

State *Pin

STD Code Phone No

Preferred Postal Address ☐ Place of work ☐ Residence

Fax No *Mobile Number

Preferred telephone number for communication

***E-mail Address** (In Block Letters)

Alternate E-mail ID (In Block Letters)

**Mandatory to be filled*

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

*Medical Council Registration No. (Attach proof)

Date D D M M Y Y Y Y State

***Educational/Academic/Technical/Professional Qualifications** (Attach proof, attach separate sheet if required)

Qualification	College/ Institution/ Board / University	Year
MBBS ☐		
MD ☐	Dept.....	
MS ☐	Dept.....	
DNB ☐	Dept.....	
DM ☐	Dept.....	
Ph.D ☐	Dept.....	
Diploma/ Fellowship/ Certificate Program ☐		

Approximate no. of patient treated in a month?

Approximate no. of patient with COPD/Asthma seen in a month?

1. Of all the asthma …….% are allergic in origin.
2. Are you confident to label your cases as Asthma or COPD on the basis of history and clinical examination only? **Yes/No**
3. Is nebulization the most effective form of administering Inhalation Therapy? **Yes/ No**
4. Is nebulization the safest form of administering Inhalation Therapy? **Yes/ No**
5. The gold standard for treatment of Chronic Stable Asthma is bronchodilators. **True/False**
6. The gold standard for treatment of COPD is bronchodilators. **True/False**
7. Non-smokers may also develop COPD. **True/False**

**Mandatory to be filled*

***Total Professional/ Clinical Experience** ☐☐ **years**

Details of Experience (Attach proof, attach separate sheet if required)

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

Any additional information (publications/ presentations/ awards/ scientific scholarships if any)
(Attach separate sheet if required)

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Signature : .....

Name : .....

Date : .....

Place : .....

D E C L A R A T I O N

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 eight 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 management of COPD/Asthma and completion of the said course will not entitle me the status of any Pulmonologist. 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 REGIONAL CENTER FACULTY

I hereby recommend, Dr. NAME OF THE PARTICIPANT ONLY.....

for enrollment in the '**Certificate Course in Management of COPD & Asthma Cycle-I**' to be conducted in my center starting in **November 2016**. I have verified all the relevant documents and he/she is eligible for enrollment.

Name & Signature of the Regional Faculty : .....

Place : ..... Date : .....

Check List of attachments with this application form (Please ✔ Tick)

1. Passport Size Photograph (1 pasted and 1 extra copy) ☐
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 Pulmonary/Respiratory/Asthma ☐
7. Experience Certificates ☐
8. Demand Draft for **INR 10,000/-**drawn in favour of
   '**Public Health Foundation of India**' payable at New Delhi ☐

Demand Draft No. | | | | | | | | | | | | Dated D D M M Y Y Y Y

Name of Bank & Branch.....

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Please mail this form along with the required documents to:

Program Secretariat- CCCA
Public Health Foundation of India
Plot No. 47, Sector - 44, Gurgaon, Haryana - 122002, India
Tel: +91 124 4781400; 0124 4781582,Fax: +91 124 472297, Mobile: +91 8527578090/ 9599051984
Website: www.phfi.org; www.ccca.org.in; Email: ccca@phfi.org

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