

**NCSI POST DOCTORAL FELLOWSHIP IN NEUROCRITICAL CARE**

**DECLARATION BY THE INSTITUITES**

|  |  |
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| **NAME OF THE INSTITUITE** |  |
| **NAME OF THE PROGRAM DIRECTOR** |  |
| **EMAIL FOR COMMUNICATION** |  |
| **MOBILE NUMBER FOR COMMUNICATION** |  |
| **FULL TIME CONSULTANTS IN THE DEPARTMENT**  |
| **SENIOR CONSULTANT****( POST MD/DNB 8 YEARS IN NEUROCRITICAL CARE PRACTICE IN A ORGANISED SETUP)** |
| S.NO | NAME  | EXPERIENCE Post Qualification (YEARS AND MONTHS ) | NCSI MEMBERSHIP Number |
| 1. |  |  |  |
| 2. |  |  |  |
| 3.  |  |  |  |
| 4.  |  |  |  |
| 5. |  |  |  |
| **CONSULTANT****(POST MD/DNB 5 YEARS IN NEUROCRITICAL CARE PRACTICE IN A ORGANISED SETUP )** |
| S.NO | NAME | EXPERIENCE (YEARS AND MONTHS) | NCSI MEMBERSHIP Number |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| **JUNIOR / Associate CONSULTANT****(POST MD/DNB 3-5 years YEARS IN NEUROCRITICAL CARE PRACTICE IN A ORGANISED SETUP)** |
| S.No | NAME | EXPERIENCE (YEARS AND MONTHS) | NCSI MEMBERSHIP Number |
| 1. |  |  |  |
| 2. |  |  |  |
| **SENIOR RESIDENT / REGISTRAR****(POST MD/DNB 0-3 YEARS )** |
| S.NO | NAME  | EXPERIENCE (YEARS AND MONTHS) | ISNACC /NCSI MEMBERSHIP No |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |

I declare that the information furnished here are true to the best of my knowledge.

Date:

Signature of PDF Director :

Signature of the HEAD OF THE INSTITUTION :