PUBLIC HEALTH FOUNDATION OF INDIA

2014 - 2019

Dr. Mohan's DIABETES EDUCATION ACADEMY a unit of DR. MOHAN'S DIABETES SPECIALITIES CENTRE

CERTIFICATE COURSE IN GESTATIONAL DIABETES MELLITUS - CYCLE V

(August 2017 - November 2017)

"This Education Program is accredited by the South Asian Federation of Endocrine Societies (SAFES)"

PARTICIPANT ENROLLMENT FORM

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

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

Father's/ Husband's Name

Affix 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

Location of practice ☐ Rural ☐ Urban

***Communication Address**

- **Place of work**

Street

Nearest Landmark

City State

*District

*Pin Phone No with STD Code

- **Residence**

Street

Nearest Landmark

City State

*District

*Pin Phone No. with STD Code

***Preferred Mailing Address** ☐ Place of work ☐ Residence

(For all program related postal communications.)

Fax No Mobile Number

Preferred telephone number for communication

Preferred time for communication (between 9.30 am to 5.30 pm)

**Mandatory to be filled*

*E-mail Address

Alternate Email ID

*Date of Birth D D M M Y Y Y Y (Attach proof , refer overleaf)

*MCI/State Council Registration No. (Attach proof , refer overleaf)

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 ☐		
DGO ☐		
MD/MS/DNB ☐	Dept.....	
DM ☐	Dept.....	
PhD ☐	Dept.....	
Any other Fellowship/ Certificate Programme ☐		

Approximate no. of patients treated in a month?

Approximate no. of patients diagnosed with: Diabetes in a month ?

Approximate no. of patients diagnosed with: Gestational Diabetes Mellitus in a month ?

***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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*Mandatory to be filled

Do you possess computer/ laptop in your workplace/ residence? Yes ☐ No ☐

Do you use internet and check e-mails regularly? Yes ☐ No ☐

Please indicate motivation and benefits you foresee in undergoing this course.

(Please attach a separate sheet if required)

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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 organized once in a month on designated Sundays and will devote self-reading time for the entire four modules in the course and participate in assessments, organized by the offering institution. 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 understand that CCGDM is not a degree but only a certificate course with the objective of training doctors in prevention and management of gestational diabetes mellitus and successful participants are not entitled to consider/mention themselves as a specialist in the same field. I also understand that this certificate course is not a 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.

Name : ..... Date : .....

Signature : ..... Place : .....

RECOMMENDATION OF REGIONAL TRAINING CENTER FACULTY

I hereby recommend Dr. .....

for enrollment in the '**Certificate Course in Gestational Diabetes Mellitus - Cycle V'** to be conducted in my center starting in **August 2017**. I have verified all the relevant documents and he/she is eligible for enrollment. I also explained to the participant that CCGDM is not a degree but only a certificate course with the objective of training doctors in prevention and management of gestational diabetes mellitus. Successful participants are advised not to mention/call themselves as specialist in the same field anywhere after completion of this course.

Name of the Regional faculty: ..... Place : .....

Signature : ..... 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. DGO Certificate ☐
6. MD, MS, DM , DNB, Ph.D – Degree (whichever is applicable, please attach all if applicable) ☐
7. Any other additional certificate for proof of diabetes certification or fellowship ☐
8. Experience Certificates ☐
9. Mode of Payment : ☐ Demand Draft ☐ NEFT*

Payment of ₹ 7,000 drawn in favour of '**Public Health Foundation of India**' payable at New Delhi

DD No./NEFT Reference No. ☐☐☐☐☐☐☐☐☐☐☐☐ Dated D D M M Y Y Y Y

Name of Bank & Branch.....

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In case of online transaction kindly mail the transaction receipt(proof of transaction) along with your name to "ccgdm@phfi.org"

NEFT DETAILS FOR ONLINE PAYMENT

PUBLIC HEALTH FOUNDATION OF INDIA
Account Branch :HDFC BANK LIMITED
Address : H-7, GREEN PARK EXTENSION, NEW DELHI
Account No : 05861110000013
RTGS/NEFT IFSC : HDFC0000586
PAN No. : AABAP4445L

Please mail this form along with the required documents to:

CCGDM
Certificate Course in
Gestational Diabetes Mellitus

Program Coordinator
Program Secretariat – CCGDM
Public Health Foundation of India
Plot No. 47, Sector 44, Gurgaon, Haryana-122002, India
Tel: +91 124 4781400 (Ext: 4578), Fax: +91 124 4722971 Mobile : 07838905053, 09650754333
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