

**APPLICATION FORM FOR  
FELLOWSHIP COURSE IN HIV MEDICINE - 2012  
CHRISTIAN MEDICAL COLLEGE, VELLORE -632 004.**

**CALENDER FOR SELECTION OF FHM CANDIDATES FOR THE YEAR 2012**

1. Last date for receiving completed applications: **20<sup>th</sup> January 2012**
2. Interviews at CMC, Vellore : **13<sup>th</sup> February 2012**
3. Commencement of course : **12<sup>th</sup> -17<sup>th</sup> March 2012**

**ALL CORRESPONDENCE/COMMUNICATION SHOULD BE ADDRESSED TO**

**The Course Coordinator,  
Fellowship in HIV Medicine,  
Infectious Diseases Training and Research Center (IDTRC),  
Medicine Unit –I, Christian Medical College & Hospital,  
Vellore, Tamil Nadu - 632004**

**Tel: (0416) 228 3617, 228 2804 ; FAX: (0416) 2211991**

**[E-mail: hivdistancelearning@cmcvellore.ac.in](mailto:hivdistancelearning@cmcvellore.ac.in)**

**NOTE: Completed applications should be sent by registered post or courier to the course coordinator by 20<sup>th</sup> January 2012. Applications received after this date, incompletely filled applications and applications without proper documents attached will be automatically rejected.**

**Additional application forms are available on: <http://www.fhmindia.org.in>**

**Please read the following instructions carefully before filling in the application form**

- 1) Filled in applications, along with all supporting documents, must be received by .
- 2) If you prefer to work on a word processor, the application form may be downloaded (PDF/WORD format available), completed on your computer and then printed out. Electronic submission through e-mail will be accepted; however this should be followed by completed application along with all the enclosures by registered post.
- 3) Ensure that your name and hospital's address is written on each sheet in the space provided.
- 4) The application form has four parts details of which are given below. Candidates will be short listed for the interview based on the information given in the application form. Ensure that all parts are completely filled. Incomplete applications will not be considered.

**Part A** - Basic information about the applicant including academic qualifications and work experience.

**Part B** - Description of the hospital/ institution where the candidate is currently working, with special reference to HIV related services offered by the hospital and specific mention of applicant's role in the same.

**Part C** – Project work is an important part of the course. Each candidate is required to undertake a HIV related project during the course period. All the applicants are required to provide an outline of the project that they wish to undertake during the course period.

**Part D** – This part of the application should be filled in by the hospital superintendent/ director / administrative officer assuring required administrative support for sanctioning leave to attend the contact courses at CMC, Vellore and support for the candidate's project work.

**Note:** If you are working alone as a general practitioner, Part D may be omitted. If you are the Senior Administrative Officer, your next senior colleague may fill Part D of the application.

***CHECK LIST:***

***Use the following check list to verify that all the sections are completely filled and all the required documents have been attached.***

1. Part A – completely filled and signed
2. Part B
3. Part C
4. Part D

***ENCLOSURES:***

5. Curriculum Vitae
6. Photocopy of degree certificates and supporting documents for workshops, conferences and trainings participated in or conducted.
7. Photograph of the applicant affixed in the space provided.
8. Demand draft Rs.200/- Payable to **CMC, Vellore association** towards application fee.

Completed application forms along with the necessary documents should reach the office **on or before 20<sup>th</sup> January 2012.**

**Applications received after the last date, incompletely filled applications and applications without proper supporting documents will be automatically rejected.**

**APPLICATION FORM**

**PART - A**

1. Applicants full name: (in capital letters)

\_\_\_\_\_

(First name)                      (Middle name)                      (Family name)

2. Date of Birth 

--	--	--

 & Age: \_\_\_\_\_ years. 3. Sex: M / F

D      M      Y



4. Name of the Hospital/ Clinic/ Project (that you are currently working in):

\_\_\_\_\_

5. Complete mailing (postal) address of your work place including pin code:

6. Telephone numbers:

a. Land line:

b. Mobile number

7. Permanent address of applicant (for correspondence):

8. E-mail address: \_\_\_\_\_

9. Have you applied for this course earlier?

10. How did you come to know about the course?

\* Letter from Vellore

\* Internet

\* Newspaper advertisement

\* E-group message

\* Magazine advertisement

\* others (please specify)

\* Informed by - (Friend / colleague/ SACS/ HIV/AIDS networks /Alumni of FHM course – provide details).

Name: \_\_\_\_\_

Hospital & Place: \_\_\_\_\_

**11. WORK EXPERIENCE:**

Please provide details of your work experience with the last three hospitals/organizations that you have worked for, starting with the present organization. In case you are currently working in more than one hospital (part time), please specify.

	Name of the institution/hospital	Position	From	To
1				
2				
3				
4				
5				

**12. DETAILS OF ACTIVITIES AND RESPONSIBILITIES IN YOUR CURRENT JOB:**

**NOTE:** Please provide details of your weekly work schedule including private practice and part time consultations. Also mention all the activities related to HIV /AIDS clinical care.

	HOSPITAL / INSTITUTION	ACTIVITIES/ RESPONSIBILITIES
<b>MONDAY</b>		
<b>TUESDAY</b>		
<b>WEDNESDAY</b>		
<b>THURSDAY</b>		
<b>FRIDAY</b>		
<b>SATURDAY</b>		
<b>SUNDAY</b>		

Name: \_\_\_\_\_

Hospital & Place: \_\_\_\_\_

**13. Describe your role/involvement in HIV/AIDS care** ( give details of how long you have been involved, describe **all HIV related activities** including clinical care, staff training, organizing programmes, administrative responsibilities and networking with NGOs as appropriate.)

**14. EDUCATIONAL QUALIFICATIONS:**

S.No	DEGREE	UNIVERSITY	Month & Year	
			From	To

Name: \_\_\_\_\_

Hospital & Place: \_\_\_\_\_

**15. OTHER HIV RELATED ACADEMIC ACTIVITIES:**

Type of activities includes – conferences, Workshops, Trainings, CMEs & others - to be specified.

Your involvement could be as participant, resource person, organizer or any others - to be specified.

S.NO	TYPE OF ACTIVITY	YOUR INVOLVEMENT	DATES

16. Why do you want to undertake the Fellowship in HIV Medicine course? How will it benefit yourself and your organization / hospital?

17. Is there a possibility that you might be transferred / change job during the period of the course?

**Declaration: The information submitted in this application and all supporting documents is complete and true.**

**Signature of the Applicant:**

**Date:**

Name: \_\_\_\_\_

Hospital & Place: \_\_\_\_\_

**PART B – Description of hospital /organization / clinic**

(If your facility does not have in patient beds, omit the related questions)

1. Which **level of care** does your organization/ hospital best fit into: (Circle appropriately).

<p><b>a. Primary care</b> – only doing outpatient care (e.g.: GP clinic)</p>	<p><b>b. Secondary care</b> – Small hospital with inpatient beds &amp; basic laboratory facilities.</p>
<p><b>c. Tertiary care</b> – large hospital with specialty services &amp; advanced investigation facilities</p>	<p><b>d. Exclusive community based programme.</b> e.g., home based care, community based prevention program etc.,</p>
<p>e. <b>Others</b> – please explain</p>	

2. Is your hospital/ institution a **teaching hospital/ training centre?**

If yes, please explain the courses/ trainings offered:

3. Which **sector** are you working in: circle appropriately.

- a. Mission – Christian Mission organizations
- b. Private clinic/ Nursing home/ Private Hospital
- c. Non Governmental Organization (NGO)
- d. Government / Quasi government
- e. others - specify

4. **Bed strength:**

a. Total number of beds available: \_\_\_\_\_

b. Average bed occupancy in the last 6 months: \_\_\_\_\_%

5. List various departments in your hospital:

Name: \_\_\_\_\_

Hospital & Place: \_\_\_\_\_

6. **Facilities available** in your hospital/clinic: Circle the appropriate option for each of the item given below:

Operation Theatre	yes	no
Labour room	yes	no
Lab facilities	yes	no
X-ray	yes	no
Ultrasound	yes	no
CT scan	yes	no
Pharmacy	yes	no
Library	yes	no
Computers	yes	no

7. **Service utility:**

- Average number of total out patients per day /month:
- Total number of inpatients in the last year:
- Total number of major surgeries conducted last year:
- Total number of deliveries conducted in the last year

8. **Staff details:**

Please provide details of staff strength of your hospital as requested below.

	number
MBBS	
Specialists / Consultants (PGs)	
Others ( homeo/ ayurveda ...)	
Nurses – graduate	
Nurses – certificate	
Lab technicians	
X- ray technicians	
Physiotherapists	
Counselors	
Social workers	
Other support / maintenance staff	

**Name:** \_\_\_\_\_

**Hospital & Place:** \_\_\_\_\_

9. The hospital/ organization/ clinic was started by \_\_\_\_\_ (name of the individual/ organization/ mission agency / others) in the year \_\_\_\_\_.  
What was the purpose for which your institution was started?

10. The hospital/organization /Clinic is presently  
Owned by:

and administered by:

11. Does your hospital/organization/clinic have any special focus in the type of patients it attempts to take care of?

12. How is your hospital funded?

**13. HIV CLINICAL CARE at your hospital/ organization/clinic:**

- a. Does your hospital/ organization/ clinic regularly see HIV patients in the outpatient department? If yes, please provide details such as since when did this activity begin; how many cases are seen per week.



**Name:** \_\_\_\_\_

**Hospital & Place:** \_\_\_\_\_

f. Do you have organized clinical care activities for any of the following;  
If yes, please give details.

I. HIV clinic -

II. Voluntary Counseling and Testing Center (VCTC)

III. Prevention of Parent To Child Transmission (PPTCT)

IV. Patient support group (PLWHA groups)

V. Others, please specify

14. Which department(s) sees HIV patients?

15. Please provide details of staff involved in HIV /AIDS care. If there is a team involved, please give details of the composition and activities of the team and your role in it.

16. Does your hospital/organization/clinic organize HIV related community based programs?  
If yes, please provide details.

**Name:** \_\_\_\_\_

**Hospital & Place:** \_\_\_\_\_

**PART C – Project outline**

Project work (of six months duration) is an essential and important part of the course. We would like you to choose a need based project that will improve HIV services to the patients accessing your hospital/organization/clinic. Towards this we request you to outline a project of six months duration that you would like to undertake during the course.

**(to see sample projects of previous students, go to website; < [www.fhmindia.org.in](http://www.fhmindia.org.in) > and click on projects)**

1. Mention the specific gaps/needs in providing HIV care at your hospital that you would like to address through this project.

2. Based on these gaps, write down a few specific objectives for the project:

**Name:** \_\_\_\_\_

**Hospital & Place:** \_\_\_\_\_

3. Write down the main project activities/steps/methods necessary to achieve these objectives :

4. How will you evaluate whether your project is effective?



Name: \_\_\_\_\_

Hospital & Place: \_\_\_\_\_

3. **HIV PROJECT**

Note: Project work is an important part of the course and each candidate is required to do a project either to initiate or improve the already existing HIV related clinical services in the hospital /organization/clinic.

- a. Please review the project plan (Part C; page no.s 10 &11 of the application) and indicate whether you feel the project will be beneficial to your hospital / organization / clinic and the patients accessing it.

- b. Do you think that the applicant will be able to implement the plan?  
Please explain mentioning specific reasons.

Name: \_\_\_\_\_

Hospital & Place: \_\_\_\_\_

**4. SUPPORT FROM THE HOSPITAL**

a. The course includes **6 weeks** of contact classes spread over a period of one year. ( details given in the prospectus). Please indicate if you would be willing to send the applicant for all the contact courses without fail. Please explain if you have any reservations.

b. How supportive would your organization be towards the proposed project? In what way would you be able to provide support for the project and help the applicant in implementing it (time, resources, administrative support and manpower)?

**Name:** \_\_\_\_\_

**Hospital & Place:** \_\_\_\_\_

c. Would your organization be able to provide financial support for project?

Full Name of the applicant:

Name of the nominating officer:

Designation of the applicant:

Designation of the nominating officer:

Name of the Hospital:

Contact details of nominating officer :

Mobile:

Tel No. :

Full address of the Hospital:

**Signature of the applicant**

Date:

**Signature of the nominating officer**

Date:

