Abstract Form

for Accreditation of Institution (Please fill the form in block letters)

Name of the Institution:

Mailing Address:

Telephone no: Fax no: Email:

Name of the Head Institution:

Designation:

Mailing Address:

Telephone no: Fax no: Email:

Status of Institution ☐ **Public Sector** ☐ **Private Sector** ☐ **Welfare Trust**

☐ **Any other** (Please Specify)

Specialty/ies to be Accredited:

Accreditation required for training leading to: (tick mark appropriate box) ☐ **MCPS** ☐ **FCPS**

Exact Designation of Unit (s) / Department(s) to be Accredited:

Institutional data

1. Are any specialty units/ departments already accredited with CPSP?

No ☐
Yes ☐ (If yes, please give details)

S.No	Name of specialty (with date of accreditation by CPSP)	Name of Departmental / Unit Heads (with postgraduate qualification)

2. Recognize by PMDC for House Job in the concerned specialty /ies?

No ☐
Yes ☐ (If yes, please mention date recognize) ______________________

3. Is the institution providing training for Diploma other than CPSP?

No ☐
Yes ☐ (If yes, please give details)

S.No	Name of Diploma [s] / Degree [s]	No. of Trainees	Name of awarding institutions / Universities

4. SUMMARY OF BED STRENGTH

Total beds in the Institution:

Male ☐ Female ☐ Children ☐

Total beds in the specialty to be accredited:

Male ☐ Female ☐ Children ☐

No. of main Intensive Care Unit beds:

Male ☐ Female ☐ Children ☐

5. SUPPORT FACILITIES:

a) Blood bank:

Is Blood bank present? Yes ☐ No ☐

Are cross matching & storage facilities available? Yes ☐ No ☐

Please furnish the list of blood products available
(Attach separate sheet if needed)

b) Laboratory:

Is laboratory available in the specialty units? Yes ☐ No ☐

Is main laboratory available in the hospital? Yes ☐ No ☐

Please supply a list of tests, which are done at the main laboratory in the following area.
(Attach separate sheet if needed)

Bio Chemical Pathology

Histopathology

Microbiology

Name & qualifications (with dates) of Head of the Laboratory.

c) Radiology:

Please furnish a list of radiological tests routinely carried out in the Hospital.
(Attach separate sheet if needed)

Specialized Diagnostic facilities:

- Ultrasound Yes ☐ No ☐
- MRI Yes ☐ No ☐
- CT scan Yes ☐ No ☐
- Radioisotope Yes ☐ No ☐
- Nuclear scan facility Yes ☐ No ☐

Name of Head of the Radiology Department

Qualification (with dates)

6. RECORD KEEPING:

System of storage and retrieval of records:

Do you produce Annual Report? Yes ☐ No ☐

How are the case record maintained? Manual ☐ Computerized ☐

7. LEARNING RESOURCES

(Please provide detail of the following. Attach separate sheet if needed)

1. Is Main Library available: Yes ☐ No ☐

2. Working days of the Library:

3. Daily working hours:

4. Total no. of Journal subscribed:

S.No	Name of Journals	Subscribed since (month, year)

OTHER RESOURCES (if yes please tick)

- **Computers**
- **Internet Access facility**
- **Video Films**
- **Specimens**
- **Models**
- **Charts**
- **Tape/ Slide Presentations**

ANY ADDITIONAL INFORMATION VOLUNTEERED (Use additional sheet)

Undertaking

We have thoroughly read and understood the Rules and Regulation of Accreditation of Units/Institution as envisaged in the "Guide to formal accreditation of training posts" and do hereby undertake to abide by them. We also promise to supply/provide any further information regarding training programme as and when required by CPSP.

We further agree to comply with the following conditions strictly:-

- **To inform CPSP immediately, if the Supervisor is transferred or not available.**
- **Not to charge tuition or ant other fee from the trainees.**
- **Every trainee must be paid stipend for training as per decision of Federal / Provincial Government. Honorary training is not registered.**
- **No other training programme will be inducted without the prior knowledge of CPSP.**
- **To apprise CPSP regarding any change in the existing faculty, equipment and facilities as and when they occur.**
- **The Institute shall also be bound to allow / permit and facilitate its teachers, fellows / supervisors to take part in academic activities of CPSP including teaching, training, workshops, courses, examinations etc when and where needed inside and outside the country. They shall be entitled for TA/DA as per institution rules and regulations.**

We also understand that failing to abide by any of the above-mentioned requirements on the part of our Unit / Institution, CPSP reserves the right to de-accredit the status of the training slots, so approved by it with immediate effect.

Name of Institution: ______________________________

Name of Head of Institute (in block letters): ______________________________

Designation: ______________________________

Address: ______________________________

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Tel: __________ Fax: __________ E mail __________

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Signature of the head of Institution (with stamp / seal)