COLLEGE OF PHYSICIANS & SURGEONS PAKISTAN

ACCREDITATION FORM

FCPS ☐ **MCPS** ☐

(Tick only one)

DISCIPLINE:

(Separate form to be filled for each discipline to be accredited)

I. INSTITUTION:

1. Name:

Head of Institution:

Designation:

Mailing Address:

Office No: (with extension if available) **Fax No:**

Cell No: **E-mail:**

Focal person (if any):

Cell No: **Office No.** **E-mail:**

2. Disclosure: (please Specify)

a). ☐ **Public Sector** ☐ **Private Sector** ☐ **Armed Forces**

☐ **Any other like Autonomous, Semi Autonomous**

3. Owns Hospital:

a) Single Hospital ☐

b) Multiple sites ☐

4. Has the following Undergraduate programmes:

a) M.B.B.S ☐

b) B.D.S ☐

c) Nursing School ☐

d) Para Medical / Medical Technical School ☐

5. **Other CPSP approved Residency Programmes in the Institution:**

S. No.	Name of Residency Programme

6. **Other ongoing University postgraduate programmes in the Institution, for example, MS, MD etc:**

S. No.	Name of other ongoing training programme

7. **Relevant Hospital Certification, for example, Standards of Punjab Health Care Commission or other relevant authority:**

☐ Yes ☐ No

8. **Approved by PM&DC for House job & Internships:**

☐ Yes ☐ No

9. **Institution Vision and a Mission Statement (if yes please mention below):**

II. OTHER SERVICES AVAILABLE IN THE INSTITUTION:

1. Pathology Services:

a) Histopathology ☐ Yes ☐ No

b) Chemical Pathology ☐ Yes ☐ No

c) Haematology ☐ Yes ☐ No

d) Microbiology ☐ Yes ☐ No

e) Virology ☐ Yes ☐ No

f) Immunology ☐ Yes ☐ No

g) Others (specify) ☐ Yes ☐ No

h) Postmortem facilities available in the hospital ☐ Yes ☐ No

Online Reports (preferred) ☐ Yes ☐ No

In charge Pathology Services:

Name:

Qualification (with dates):

2. Transfusion Services: ☐ Yes ☐ No

3. Pharmacy Services Institutional (preferred): ☐ Yes ☐ No

Incharge Pharmacist:

Name:

Qualification (with dates):

4. Radiology/ Imaging:

Facilities available in the institution			Make & type of Machine
X-rays	☐ Yes	☐ No	
Ultrasonography	☐ Yes	☐ No	
CT Scan	☐ Yes	☐ No	
MRI	☐ Yes	☐ No	
Mammogram	☐ Yes	☐ No	

Others (specify) _____

5. Medical Records:

☐ Manual ☐ Computerized ☐ Mixed ☐ MIS

Central Record Keeping of the Institution ☐ Yes ☐ No

III. DEPARTMENT:

1. Unit (Seeking Accreditation):_____

Name of Head of Department: _____

Designation: _____

Mailing Address: _____

_____

Office No: (with extension if available) _____ Fax No: _____

Cell No: _____ E-mail: _____

Name of the Head of Unit (if different from above):

Designation:

Mailing Address:

Office No: (with extension if available) Fax No:

Cell No: E-mail:

2. Specialty Specific Equipments:

S. No.	Equipment(s) Name	Number	Model

(Attach a separate sheet if required)

3. **Bed Strength of the Unit:**

Total number of beds: _____

Male: ☐ Female: ☐

No. of ICU Beds _____

No. of High Dependency Beds _____

Other Beds _____

Private Rooms: ☐ Semi Private Rooms: ☐

4. **Average inpatients stay in the Ward during the last 03years:** _____

5. **Bed Occupancy Rate in last 06 months:** _____

6. **Work Load: Kindly provide us workload statistics for last 06 months**

Number of OPD patients/ month.
Number of Admitted patients (Indoor) month.

a) List of 20 important conditions seen in unit in the last six months in order of decreasing frequency.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

Statistics of Procedures performed in last 06 months

b) List the procedures performed in the unit in last six months in order of decreasing frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

c) Total number of deaths in the unit in the previous 06 months: _____

6. Seminar / Conference Room:

Seminar Room near the Ward: ☐ Yes ☐ No

Audio Visual Aids Resources:

Multimedia: ☐ Yes ☐ No

Flip Charts / white board etc: ☐ Yes ☐ No

Photo Copier: ☐ Yes ☐ No

Scanner: ☐ Yes ☐ No

Photographer available: ☐ Yes ☐ No

Others (specify): _____

IV. FACULTY:

1. **(Please enclose letter of appointment of the faculty members and provide pertinent Curriculum Vitae of each faculty member listed):**

S. No.	Name	Designation & Date of joining the present post	Qualification with year / Institution	Supervisor Status with their Registered Supervisor Number

2. **Able to devote sufficient time to fulfill their supervisory and teaching responsibilities:**
(Please attach proposed / existing weekly schedule of the whole faculty)
(Evidence of Faculty Evaluation and Feedback to Supervisors)

_____

_____

3. **Is the unit complete with Professor, Associate Professor, Assistant Professor and / or Senior Registrar?**

☐ Yes ☐ No

4. **Designation of the posts yet to be filled:**

_____

_____

_____

_____

5. **Faculty Related Policies:**

_____

_____

_____

_____

6. **Faculty Research & Publications:** (Add additional sheet if required)

_____

_____

_____

_____

V. ACADEMIC PROGRAMME:

1. **Please provide details of the existing teaching programme:**

This would include lectures, demonstrations, small group discussions, clinical-pathological conferences, ward rounds, OPD work, casualty and emergency work, rotation duties in various sub-specialties, morbidity and mortality meetings, self learning and others, as applicable.

2. Where and how each competency is acquired (attach separate sheets):

a) Patient Care.

b) Knowledge & Critical Thinking.

c) Technical Competence.

d) Communication Skills.

e) Team Work.

f) Self Education and Teaching Skills.

g) Research.

h) Are the following workshops arranged for the trainees?

i. Advocacy: ☐ Yes ☐ No

ii. Professionalism: ☐ Yes ☐ No

iii. Leadership: ☐ Yes ☐ No

3. Quantum of Supervision & Independence for the trainees:
(Technical / procedural / academic)

All residency programmes require:

- A minimum of 40 duty hours per week for clinical specialties excluding emergency duties and the number of Sundays on call per month depending on the number of trainees available in the unit.

_____

_____

_____

_____

4. <u>Academic Time</u> (Please attach Residents weekly schedule):

i. Minimum of **<u>04 hours per week</u>** of protected time should be allocated to academic (educational & research activities & responsibilities).

OR

ii. You are in favour of a day reserved for study.

☐ Yes ☐ No

VI. INFORMATION REGARDING PROPOSED RESIDENCY PROGRAMME:

1. Selection criteria:

Medical Degree	House Job / Internship	Fellowship Part- I
MBBS / BDS	One year	Passed within last 3 years

2. Describe the selection process:

a. Advertisement ☐ Yes ☐ No

b. Written test & entrance interview ☐ Yes ☐ No

c. Only interview ☐ Yes ☐ No

d. Open merit for candidates ☐ Yes ☐ No

3. No. of residents to be admitted in Jan/ July sessions each year: _____

4. Electives and / or Resident Exchange Programmes:

a. Are all your required rotations inter departmental in CPSP approved Units / Departments:

☐ Yes ☐ No

b. Electives: ☐ Yes ☐ No

c. External Rotations where CPSP approved disciplines are not available in the Institutions:

☐ Yes ☐ No

External Rotations of Residents (attach document/s of agreement from relevant institutions–Signed MoU's):

Specialties	Name of Institute	Duration	Year of training

d. Resident Exchange Programs (attach MoU): ☐ Yes ☐ No

VII. EDUCATION RESOURCES.

1. **Department of Medical Education in the Institution:** ☐ Yes ☐ No

   a) Assistance and guidance in the Curriculum. ☐ Yes ☐ No

   b) Capacity building for Faculty.

      – Mandatory ☐ Yes ☐ No

      – Optional and available ☐ Yes ☐ No

2. **Library:**

   a) Central Library of Institution. ☐ Yes ☐ No

   b) Ward collection of specialty books & specialty journals. ☐ Yes ☐ No

   c) Computer access & internet facilities available close to workplace. ☐ Yes ☐ No

i. Basic Textbooks of specialty available in the Unit / ward:

List of Books	Editions No.	Yes / No

ii. List Of Journals In The Specialty Received Regularly:

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

3. **Skills Lab.** ☐ Yes ☐ No

4. **Patient Bank.**

   a) Real Patients. ☐ Yes ☐ No

   b) Simulated Patients. ☐ Yes ☐ No

UNDERTAKING

We have read and understand 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:-

- **To inform CPSP immediately, if the Supervisor is transferred or not available.**
- **Not to charge tuition or any other fee (in respect of training) 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 introduced without the prior knowledge of CPSP. (i.e. dilution of training is not to occur).**
- **To apprise CPSP regarding any change in the existing faculty, equipment and facilities as and when they occur.**
- **No trainee will be inducted simultaneously in CPSP program along with another Program.**
- **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, may result in suspension of any accreditation granted.

Name of Institution: _____

Name of Department: _____

Name of Unit: _____

Name of Unit Head (in block letters): _____

Designation: _____

Address: _____

_____

Tel: _____ Fax: _____ E mail _____

_____

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

Name (in block letters): _____

Designation: _____

Address: _____

_____

Tel: _____ Fax: _____ E mail _____

_____

Counter-signature of the head of Institution (with stamp / seal)

CHECK LIST

For submission of Accreditation request

1. Letter of Intent from institution to the Registrar, CPSP.
2. Accreditation Form duly completed, in triplicate, separately for accreditation of each unit.
3. Detailed CV's of teaching faculty indicating their PG qualification with date of acquisition.
4. Photocopies of participation in mandatory workshops by prospective/ respective supervisor/s. RTMC Registered Supervisor/s may send copy of their Registration Certificate/s only.
5. Identity of Proposed Fellowship/ Membership Programme.
6. Any other additional information may be included, if considered relevant.

ACCREDITATION FEE:

After completing the documentation; the Accreditation Fee shall be charged as per following breakup.

PUBLIC & ARMED FORCES INSTITUTIONS:

1.	Initial Processing Fee	@ Rs. 5,000/= per unit
2.	Basic Fee to visit institute	Rs.70,000/=
3.	Unit Fee	@ Rs.30,000/= per unit

For Accreditation of one discipline; you may remit a Bank Draft of Rs.105,000/- only in favour of CPSP; add Rs. 35,000/- for each additional discipline seeking accreditation.

PRIVATE INSTITUTIONS:

1.	Initial Processing Fee	@ Rs. 5,000/= per unit
2.	Basic Fee to visit institute	Rs.80,000/=
3.	Unit Fee	@ Rs.40,000/= per unit

For Accreditation of one discipline; you may remit a Bank Draft of Rs.125,000/- only in favour of CPSP; add Rs.45,000/- for each additional discipline seeking Accreditation.