Dr. D. Y. Patil Medical College, Hospital and Research Centre

(Re-accredited by NAAC with a CGPA of 3.62 on a four point scale at 'A' grade)

Pimpri, Pune - 411 018

Contact No. 020-27805900 /100 Email:-pgsection.medical@dpu.edu.in

ADVERTISEMENT

Applications are invited for Various Certificate Courses in prescribed format provided on our website. The details are as follows:-

CERTIFICATE COURSES AFTER 10+2/GRADUATION

Sr. No	Course	Dept.	Duration	Eligibility	Intake	Fees
1	Certificate Course in EMG/NCS Technician	Neurology	6 Months	12th Science	02	15,000/-
2	Certificate Course in EEG Technician	Neurology	6 Months	12th Science	02	10,000/-
3	Certificate Course in Advance Microbiology Laboratory Techniques	Microbiology	6 Months	All B.Sc. with DMLT qualified Lab Technicians/M.Sc. (Microbiology & Biotechnology)	10	20,000/-
4	Medical Record Librarian	Community Medicine	6 Months	B.Sc.	30	30,000/-
5	Urology Technician Cum OT Assistant	Urology	6 Months	12th Science with Biology & Physics	04	20,000/-
6	Certificate Course in X-Ray Technician	Radiology	1 Year	12th Science with Physics, Chemistry & Biology	07	50,000/-

Admission Procedure : a) Last date of submitting of application is 18th September 2018.

b) Selection shall be done on inter-se merit.

c) Commencement of Course 19th September 2018.

Interested candidates shall submit the scanned copies of the mark sheets, passing certificates and Photo ID Proof to above mentioned E-mail address.

(Dr. J. S. Bhawalkar)

D E A N

Dr. D. Y. Patil Medical College, Hospital and Research Centre, Pimpri, Pune –411018

Dr. D.Y. PATIL VIDYAPEETH, PUNE
(Deemed To Be University)
(Re-accredited by NAAC with a CGPA of 3.62 on a four point scale at 'A' grade)

Contact No. 020-27805900 / 5100 **Email:-pgsection.medical@dpu.edu.in**

Application for Certificate course in: - _____

Attach Photo

Name:- _____

Date of Birth: - _____ **Age:-**_____

E-mail ID:-_____

Mobile no.:- _____ **Residential no :-** _____

Aadhar Card no:-_____ (Attach Proof)

Pan Card no: - _____ (Attach Proof)

Residential address:_____

_____

Year of Passing MBBS/any Graduation:-_____ (Attach degree/ passing certificate)

Year of Passing MD/DNB/CPS/any Post Graduation:-_____ (Attach degree/ passing certificate)

Details of Registration with Medical Council if applicable: -

- **MBBS** (Registration no. & Year) _____(Attach Proof)
- **MD/ DNB/ CPS** (Registration no. & Year) _____(Attach Proof)

Present working status: -

_____

_____ (Attach Proof)

Note:- Certified that the above information is correct and I am willing to work in the Department on full time basis during the period of training.

Signature of Applicant

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