



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 Fellowship Programmes in prescribed format provided on our website. The details are as follows:-

FELLOWSHIP PROGRAMMES

Sr. No	Course	Dept.	Duration	Eligibility	Intake	Fees
1	Post Doctoral Fellowship in Epilepsy	Neurology	1 Year	DM/DNB Neurology	02	2,00,000/-
2	Fellowship in Neonatology	Paediatrics	1 Year	MD/DNB/DCH Paediatrics (University or CPS if obtained on or after December 2009)	01	1,00,000/-
3	Fellowship in Paediatrics Neurology	Paediatrics	1 Year	MD Paediatrics	03	1,00,000/-
4	Fellowship in Paediatrics Critical Care	Paediatrics	1Year	MD/DNB Paediatrics	02	1,00,000/-
5	Fellowship in Sport Injury	Orthopaedics	1 Year	Postgraduate Diploma or M.S/M.D/DNB, M.Ch Orthopaedic in Surgery	04	1,00,000/-

6	Fellowship in Musculoskeletal Imaging	Radio-diagnosis	1 Year	MD/DNB Radio-diagnosis	02	1,00,000/-
7	Fellowship in Breast Imaging	Radio-diagnosis	1 Year	MD/DNB Radio-diagnosis	02	1,00,000/-
8	Fellowship in Clinical Orientation and Counseling Psychology	Psychiatry	1 Year	M. A. (Psychology) / Master of Social Work (MSW)	20	25,000/-

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 Fellowship course in: - _____

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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