



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 MBBS/ MD/ DNB

Sr. No	Course	Dept.	Duration	Eligibility	Intake	Fees
1	Certificate Course in Adolescent Health	Paediatrics	6 Months	Medical Graduate (MBBS) and above	02	40,000/-
2	Certificate Course in Early Interventions and Development Therapy	Paediatrics	1 Year	MD/DNB/DCH/ Neonatal Fellows/Masters in Paediatrics Physiotherapy/ Masters in Paediatrics Nursing	04	40,000/-
3	Certificate Course in Sport Trauma	Orthopaedics	6 Month	Medical Graduate (MBBS) from an MCI recognized Medical College/BPT	05	50,000/-
4	Clinical Echocardiography	Medicine	6 Months	MD / DNB General Medicine	05	60,000/-
5	Certificate Course in Karyotyping	Anatomy	3 Months	MBBS	10	20,000/-

6	Organ Transplant Coordinator	Anatomy	6 Months	MBBS, BAMS, BHMS, M.Sc.(Medical Anatomy / Physiology), PG in Medical Psychology / Sociology Nurses with B.Sc. Nursing, trained for Intensive Care	25	25,000/-
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Admission Procedure : a) Last date of submitting of application is 31th December 2018.
b) Selection shall be done on inter-se merit.

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)

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Email:-pgsection.medical@dpu.edu.in

Application for Certificate 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

(-----)

Attach
Photo