



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 - 411018

Contact No. 020-27805900 /100

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

ADVERTISEMENT

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

Short Term Training Courses

Sr. No	Course	Dept.	Duration	Eligibility	Intake	Fees
1	STTP in Advanced Micromanipulation	IVF & Endoscopy Center	03 Days – 06 Hrs. per day	DGO/MD/MS/DNB OBG, Anatomy, Pathology, Microbiology	2	50,000/- +18% GST
2	STTP in Basic Andrology	IVF & Endoscopy Center	2 Days – 16 Hrs.	Bachelor of Life Science	2	30,000/- + 18% GST
3	STTP in Advance Andrology	IVF & Endoscopy Center	03 Days – 06 Hrs. per day	MD/MS/DPP/DNB- OBG, Anatomy, Pathology, Practicing Andrologist	2	30,000/- + 18% GST
4	STTP in Embryo Biopsy	IVF & Endoscopy Center	03 Days – 06 Hrs. per day	Practicing Embryologist with minimum TWO years of experience of ICSI from ICMR accredited IVF Center.	2	95,000/- + 18% GST
5	STTP in Vitrification	IVF & Endoscopy Center	03 Days – 06 Hrs. per day	MSc Clinical Embryology/ MSc Life Sciences with Fellowship in Clinical Embryology	2	50,000/- + 18% GST

Admission Procedure : a) Last date of submission application is 10th October 2021.

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

c) Commencement of Course 15th October 2021.

Interested candidates should mail the application form along with scanned copies of their mark sheets, Passing certificate and Photo ID Proofs to the above mentioned e-mail address.

Sd/-
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)

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Application for Fellowship course in: - _____

Name:- _____

Attach Photo

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 DGO/MS/MD/DNB/Dip./ any Post Graduation:- _____ (Attach degree/ passing certificate)

Details of Registration with Medical Council if applicable: -

- MBBS (Registration no. & Year) _____ (Attach Proof)

- MD/ DNB/Dip (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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