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 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	Fellowship in Gyane Endoscopy	Obst. & Gynecology	1 Year	M.D/ M.S/ D.N.B (OBGY)	02	Rs.2,00,000/- Per Year
2	Fellowship in Reproductive Medicine.	Obst. & Gynecology	1 Year	M.D/ M.S/ D.N.B (OBGY)	02	Rs.3,00,000/- Per Year
3	Fellowship in Advanced Spine Surgery	Neurosurgery	1 Year	MS/DNB (Orthopedics)	02	Rs.1,00,000/- Per Year
4	Fellowship in Cytopathology	Pathology	1 Year	MD/ DNB (Pathology)	02	Rs.1,00,000/- Per Year
5	Fellowship in Surgical Pathology	Pathology	1 Year	MD/DNB (Pathology)	02	Rs.1,00,000/- Per Year

Admission Procedure : a) Last date of submission application is 18th December 2020.

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

c) Commencement of Course 1st January 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/-
Mr. Uday Shende
REGISTRAR

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)
(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: - _____

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/Dip./CPS/any Post Graduation:-_____ (Attach degree/ passing certificate)

Details of Registration with Medical Council if applicable: -

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