



NATIONAL BOARD OF EXAMINATIONS
(Ministry of Health & Family Welfare, Govt. of India)
ANSARI NAGAR, MAHATMA GANDHI MARG, (RING ROAD), NEW DELHI - 110 029



NON-SCANNABLE APPLICATION FORM

Application Form No. _____

for Registration as DNB Trainee - **20** _____

To be filled up for registration within one month of their joining as a DNB trainee.

Subject: _____

Institute: _____

1. Name (CAPITAL LETTERS) (Leave a blank space between each part of the name)

2. Father's/Husband's Name (CAPITAL LETTERS) (Leave a blank space between each part of the name)

3.a) MCI/SMC Reg. No.

3.b) Date of Regn.

3.c) State

4. Sex

Male Female

5. Date of Birth

6. Category

General SC
 ST OBC

7. Colour Photograph

- Paste here (do not pin or staple) a recent passport size photograph as per "INSTRUCTIONS FOR PHOTOGRAPHS" on the inner side of back cover of the Prospectus.
- The photograph should NOT exceed this box.
- The photograph to be affixed here should be attested.
- If the photograph is not clear, the application will be rejected.

8. Date of Joining with Institution as a DNB Trainee w.e.f from

____ to ____

9. Duration of P.G. Diploma w.e.f from (If applicable)

____ to ____

10. Address (Correspondence Address)

Name : _____
Address : _____

City : _____
State : _____
Pin Code : _____

11. Detail of Registration Fee

Rupees : _____
DD No.: _____
DD Date: _____
D D M M Y Y Y Y
Bank Name: _____
Details of the candidates name, hospital name and the speciality for which required to be mentioned on the reverse of draft.

12. Mobile Number

13. E-mail ID (Write in CAPITAL LETTERS & clear manner)

DECLARATION & CERTIFICATION

I here by declare and certify that:

- I have read the general instructions and the rules and regulations of NBE in Bulletin of Information and shall abide by them.
- Particulars given in this application form are true and accurate to the best of my knowledge and belief.
- The documents submitted as evidence of above facts are duly attested by a Gazetted Officer of Govt. of India.
- I understand that in case any of the facts stated by me is/are found to be false or any of the documents enclosed by me is/are found to be false, I am liable to be disqualified as registered as a DNB Trainee/Candidate for DNB programme or any other appropriate action deemed fit by NBE can be taken against me.
- I understand that I am eligible as per instructions given in Bulletin of Information, however, NBE reserves the right to determine final eligibility NBE further reserves the right to cancel the candidature if ineligibility found at any stage.

FOR OFFICE USE ONLY

NOTE: PHOTOCOPY OF THE FILLED UP APPLICATION FORM MUST BE RETAINED BY THE CANDIDATE FOR FUTURE USE.

Date: _____

Signature of the Candidate

14. Details of Examination Passed (Attested copies of Certificates to be attached.)

| Examination | Subject | Medical College | University | State | Month/Year | No. of attempts |
|-----------------------|---------|-----------------|------------|-------|------------|-----------------|
| MBBS | | | | | | |
| CET - NBE/ Primary | | | | | | |
| NBE Final | | | | | | |
| PG Diploma | | | | | | |
| MD/MS | | | | | | |
| DM/MCh | | | | | | |
| Others | | | | | | |

15. Topic of thesis (protocol is to be submitted within 3 months of joining the Institution)

Signature of Candidate

Signature of Head of Department
(With Department Seal)

Counter signed by the Head of Institution
(With Institution Seal)

Checklist of attested photocopies of certificates & enclosures attached : (Please tick)

- | | |
|---|--------------------------|
| 1. MBBS Degree Certificate | <input type="checkbox"/> |
| 2. CET - NBE / Primary Passed Certificate. | <input type="checkbox"/> |
| 3. P.G. Diploma Pass Certificate. | <input type="checkbox"/> |
| 4. MCI/SMC Registration Certificate | <input type="checkbox"/> |
| 5. Certificate of training to be undergone in the required format. | <input type="checkbox"/> |
| 6. Registration fee (DD Rs. 1500/- in favour of National Board of Examination, New Delhi) | <input type="checkbox"/> |
| 7. MD/MS/DNB Certificate | <input type="checkbox"/> |
| 8. CET Super Specialities Pass Certificate | <input type="checkbox"/> |
| 9. Annexures I-12 | <input type="checkbox"/> |

DNB Trainee's Registration – Check List

Name of Institution : _____
Address : _____
Specialty : _____
No. of Seats : _____ Accredited upto _____

Name of Trainee : _____
Trainee's Address : _____

Contact Nos. : _____ Mobile No. _____
Email id : _____

Specialty : _____ (Primary / Secondary / Post Doctoral)
Date of Joining : _____ Session _____ Duration of training: 3 yrs / 2 yrs
Regn. Fees DD No. : _____ Date _____ Bank _____

| Sr. No. | Details of Registration Documents | Whether Attached | | Signature of the Head of Institution |
|---------|--|------------------|----|--------------------------------------|
| | | Yes | No | |
| 1 | Application form duly filled, signed by HOD and HOI with seal. | | | |
| 2 | Training Certificate in Format No.1/2/3/4/5/6/7/8/9 | | | |
| 3 | Demand Draft of Rs. 1500/- (Registration fees) | | | |
| 4 | Attested Copy of MBBS Degree | | | |
| 5 | Attested Copy of MCI / SMC Registration Certificate | | | |
| 6 | Attested Copy of Valid CET Certificate | | | |
| 7 | Attested Copy of PG Diploma Certificate | | | |
| 8 | Attested Copy of PG Degree (MD/MS/DNB) Certificate | | | |
| 9 | Annexure (1-9) | | | |
| 10 | Annexure 10 (Attested copy of Accreditation letter) | | | |
| 11 | Annexure-11 (Attested copy of MCI's recognition letter (for Medical Colleges)) | | | |
| 12 | Annexure-12 - Certificate with details of Faculty (for Medical Colleges) | | | |
| 13 | Any other document | | | |

It is certified that I have personally verified all the above documents. I understand that in case of any inaccuracy / deficiency detected by NBE, the registration of the above candidate will be cancelled / withdrawn with no Legal liability on the part of the National Board of Examinations.

Signature of DNB Trainee
Date :

Signature of the Head of Institution
(with seal)

Certificate to be issued by NBE Accredited Institutions enrolling CET-NBE passed DNB Primary trainees

This certificate must be issued on the official letter head of the Accredited Institutions only.
Incorrect / Incomplete information may lead to rejection of registration

FORMAT NO. 1

(Certificate in respect of CET-NBE passed Primary trainees, in Broad Specialties / Integrated Super Specialities)

1. Certified that the department of _____ of this NBE Accredited Institution is recognized by the National Board of Examinations, for training of CET-NBE passed DNB primary trainees, vide its letter No. _____ dated _____ for _____ number of seats each year and valid up to _____ (month & year).
2. Also certified that Dr. _____ has been selected as a DNB trainee for the _____ session and will undergo training in DNB (_____) for a period of 3/6* years w.e.f. _____ (day) _____ (month) _____ (year).
3. He / She has passed the CET-NBE examination in _____ (Month & year)
4. He / She will be writing his / her Thesis under Dr. _____ who is a Senior Post Graduate Faculty of this Institution.
5. Dr. _____ will be maintaining a log book.
6. He / She will be completing his / her training on _____ (day) _____ (month) _____ (year).

* 6 Years for Integrated Super Specialty courses in Neuro Surgery, Paediatric Surgery & Plastic Surgery.

SIGNATURE OF THE HEAD OF THE DEPARTMENT
(With seal and date)

SIGNATURE OF THE HEAD OF THE INSTITUTION
(With seal and date)

Certificate to be issued by NBE Accredited Institutions enrolling **DNB Secondary trainees**

This certificate must be issued on the official letter head of the Accredited Institutions only.
Incorrect / Incomplete information may lead to rejection of registration

FORMAT NO. 2

(Certificate in respect of Post Graduate Diploma passed Secondary trainees, in Broad Specialties)

1. Certified that the department of _____ of this NBE Accredited Institution is recognized by the National Board of Examinations for training of Post Graduate Diploma passed DNB secondary trainees vide its letter No. _____ dated _____ for _____ number of seats each year and valid up to _____ (month & year).
2. Also certified that Dr. _____ has been selected as a DNB trainee for the _____ session and will undergo training in DNB (_____) for a period of 2 years w.e.f. _____ (day) _____ (month) _____ (year).
3. He / She has also been appointed as a Registrar / Sr. Resident / Tutor on a paid teaching post in the specialty of _____ after passing MCI recognized Post Graduate Diploma of 2 years in the same specialty.
4. He / She will be writing his / her Thesis under Dr. _____ who is a Senior Post Graduate Faculty of this Institution.
5. Dr. _____ will be maintaining a log book.
6. He / She will be completing his / her training on _____ (day) _____ (month) _____ (year).
7. This hospital / institution has selected Dr. _____ as the CET passed Primary candidate to whom the above mentioned Post Graduate Diploma passed Secondary trainee will impart training during the first year.

SIGNATURE OF THE HEAD OF THE DEPARTMENT
(With seal and date)

SIGNATURE OF THE HEAD OF THE INSTITUTION
(With seal and date)

Certificate to be issued by NBE Accredited Institutions enrolling **DNB Super Specialty trainees**

This certificate must be issued on the official letter head of the Accredited Institutions only.
Incorrect / Incorrect / Incomplete information may lead to rejection of registration

FORMAT NO. 3

(Certificate in respect of Post Graduate Degree passed DNB trainees, in Super Specialties)

1. Certified that the department of _____ of this NBE Accredited Institution is recognized by the National Board of Examinations for training of Post Graduate passed DNB Super Specialty trainees vide its letter No. _____ dated _____ for _____ number of seats each year and valid up to _____ (month & year).
2. Also certified that Dr. _____ has been selected as a DNB trainee for the _____ session and will undergo training in DNB (_____) for a period of 3 years w.e.f. _____ (day) _____ (month) _____ (year).
3. He / She has qualified the MCI / NBE recognized 3 year Post Graduate Degree course of MD / MS / DNB in _____ and is eligible for admission to the DNB Super Specialty course of _____.
4. He / She has also qualified the Board's CET (SS) in _____ (year)
5. He / She will be writing his / her Thesis under Dr. _____ who is a Senior Post Doctoral Faculty of this Institution.
6. Dr. _____ will be maintaining a log book.
7. He / She will be completing his / her training on _____ (day) _____ (month) _____ (year).

SIGNATURE OF THE HEAD OF THE DEPARTMENT
(With seal and date)

SIGNATURE OF THE HEAD OF THE INSTITUTION
(With seal and date)

Certificate to be issued by the Medical College enrolling DNB Primary trainees under 1 : 1 Teacher Trainee ratio clause

This certificate must be issued on the official letter head of the Medical College only.
Incorrect / Incomplete information may lead to rejection of registration

FORMAT NO. 4

(Certificate in respect of CET-NBE passed Primary trainees, in Broad Specialties)

1. Certified that the department of _____ of this Medical College is recognized by the Medical Council of India for training of MD / MS candidates vide its letter No. _____ dated _____ for _____ number of seats each year and valid up to _____ (month & year).
2. Also certified that Dr. _____ has been selected as a DNB trainee for the _____ session and will undergo training in DNB (_____) for a period of 3 years w.e.f. _____ (day) _____ (month) _____ (year).
3. He / She has passed the CET-NBE examination in _____ (Month & year)
4. He / She will be writing his / her Thesis under Dr. _____ who is a MCI approved Post Graduate teacher.
5. The department of _____ of this Medical College is maintaining the requisite Teacher Trainee ratio of 1:1 (i.e. the above Teacher has taken only One Post Graduate trainee for the Board's examination and that no other MD / MS / DNB candidate of the College has been registered under the above Teacher during the current academic year).
6. Dr. _____ will be maintaining a log book.
7. He / She will be completing his / her training on _____ (day) _____ (month) _____ (year).

SIGNATURE OF THE HEAD OF THE DEPARTMENT
(With seal and date)

SIGNATURE OF THE HEAD OF THE INSTITUTION
(With seal and date)

Certificate to be issued by the Medical College enrolling DNB Secondary trainees under 1 : 1 Teacher Trainee ratio clause

This certificate must be issued on the official letter head of the Medical College only.
Incorrect / Incomplete information may lead to rejection of registration

FORMAT NO. 5

(Certificate in respect of Post Graduate Diploma passed Secondary trainees, in Broad Specialties)

1. Certified that the department of _____ of this Medical College is recognized by the Medical Council of India for training of MD / MS candidates vide its letter No. _____ dated _____ for _____ number of seats each year and valid up to _____ (month & year).
2. Also certified that Dr. _____ has been selected as a DNB trainee for the _____ session and will undergo training in DNB (_____) for a period of 2 years w.e.f. _____ (day) _____ (month) _____ (year).
3. He / She has also been appointed as a Registrar / Sr. Resident / Tutor on a paid teaching post in the specialty of _____ after passing MCI recognized Post Graduate Diploma of 2 years in the same specialty.
4. Dr. _____ will be working with full clinical responsibilities as that of 2nd and 3rd year Resident, for the first year DNB trainees of the specialty.
5. He / She will be writing his / her Thesis under Dr. _____ who is a MCI approved Post Graduate teacher.
6. The department of _____ of this Medical College is maintaining the requisite Teacher Trainee ratio of 1:1 (i.e. the above Teacher has taken only One Post Graduate trainee for the Board's examination and that no other MD / MS / DNB candidate of the College has been registered under the above Teacher during the current academic year).
7. This hospital / institution has selected Dr. _____ as the CET passed Primary candidate to whom the above mentioned Post Graduate Diploma passed Secondary trainee will impart training during the first year.
8. Dr. _____ will be maintaining a log book.
9. He / She will be completing his / her training on _____ (day) _____ (month) _____ (year).

SIGNATURE OF THE HEAD OF THE DEPARTMENT
(With seal and date)

SIGNATURE OF THE HEAD OF THE INSTITUTION
(With seal and date)

Certificate to be issued by the Medical College enrolling DNB Super Specialty trainees under 1 : 1 Teacher Trainee ratio clause

This certificate must be issued on the official letter head of the Medical College only.
Incorrect / Incomplete information may lead to rejection of registration

FORMAT NO. 6

(Certificate in respect of Post Graduate Degree passed DNB trainees, in Super Specialties)

1. Certified that the department of _____ of this Medical College is recognized by the Medical Council of India for training of DM / MCh candidates vide its letter No. _____ dated _____ for _____ number of seats each year and valid up to _____ (month & year).
2. Also certified that Dr. _____ has been selected as a DNB trainee for the _____ session and will undergo training in DNB (_____) for a period of 3 years w.e.f. _____ (day) _____ (month) _____ (year).
3. He / She has qualified the MCI / NBE recognized 3 year Post Graduate Degree course of MD / MS / DNB in _____ and is eligible for admission to the DNB Super Specialty course of _____.
4. He / She has also qualified the Board's CET (SS) in _____ (year)
5. He / She will be writing his / her Thesis under Dr. _____ who is a MCI approved Post Doctoral teacher.
6. The department of _____ of this Medical College is maintaining the requisite Teacher Trainee ratio of 1:1 (i.e. the above Teacher has taken only One Post Doctoral trainee for the Board's examination and that no other DM / MCh / DNB candidate of the College has been registered under the above Teacher during the current academic year).
7. Dr. _____ will be maintaining a log book.
8. He / She will be completing his / her training on _____ (day) _____ (month) _____ (year).

SIGNATURE OF THE HEAD OF THE DEPARTMENT
(With seal and date)

SIGNATURE OF THE HEAD OF THE INSTITUTION
(With seal and date)

Certificate to be issued by NBE Accredited Institutions enrolling **Post Doctoral Fellowship Trainees**

This certificate must be issued on the official letter head of the Accredited Institutions only.
Incorrect / Incorrect / Incomplete information may lead to rejection of registration

FORMAT NO. 7

(Certificate in respect of Post Doctoral Fellowship trainees)

1. Certified that the department of _____ of this NBE Accredited Institution is recognized by the National Board of Examinations for training of NBE Fellowship Entrance Exam passed Post Doctoral Fellowship trainees vide its letter No. _____ dated _____ for ___ number of seats each year and valid up to _____ (month & year).
2. Also certified that Dr. _____ has been nominated for training in Post Doctoral Fellowship of _____ (subject) by the Board for the 2008 – 2009 session.
3. He / She has qualified the MCI / NBE recognized 3 year Post Graduate / Post Doctoral course of MD / MS / DNB / DM / Mch / in _____ and is eligible for admission to the Post Doctoral Fellowship in _____.
4. He / She has also qualified the Board's Fellowship Entrance Exam (FEE) for admission to _____ (subject) in _____ (year of exam).
5. Dr. _____ will undergo training in PDF in _____ (subject) for a period of 2 years w.e.f. _____ (day) _____ (month) _____ (year).
6. He / She will be completing his / her training on _____ (day) _____ (month) _____ (year).
7. Dr. _____ will be maintaining a log book.

SIGNATURE OF THE HEAD OF THE DEPARTMENT
(With seal and date)

SIGNATURE OF THE HEAD OF THE INSTITUTION
(With seal and date)

Certificate to be issued by NBE Accredited Institutions enrolling **DNB in Family Medicine**

This certificate must be issued on the official letter head of the Accredited Institutions only.
Incorrect / Incomplete information may lead to rejection of registration

FORMAT NO. 8

(Certificate in respect of DNB (Family Medicine) trainee

1. Certified that the Department of Family Medicine of this NBE Accredited Institution is recognized by the National Board of Examinations, for training of DNB (Family Medicine) trainees, vide its letter No. _____ dated _____ for ____ number of seats each year and valid up to _____(month & year).
2. Also certified that Dr. _____ has been selected as a DNB trainee for the _____ session and will undergo training in DNB (Family Medicine) for a period of 3 years w.e.f. _____(day) _____ (month) _____(year).
3. He / She will be undergoing training as per the curriculum given by the National Board of Examinations.
4. He / She will be writing his / her Thesis under Dr. _____ who is a Senior Post Graduate Faculty of this Institution.
5. Dr. _____ will be maintaining a log book.
6. He / She will be completing his / her training on _____(day) _____ (month) _____(year).

SIGNATURE OF THE HEAD OF THE DEPARTMENT
(With seal and date)

SIGNATURE OF THE HEAD OF THE INSTITUTION
(With seal and date)

Certificate to be issued by NBE Accredited Institutions enrolling **DNB in Rural Surgery**

This certificate must be issued on the official letter head of the Accredited Institutions only.
Incorrect / Incomplete information may lead to rejection of registration

FORMAT No. 9

(Certificate in respect of DNB (Rural Surgery) trainee

1. Certified that the Department of Rural Surgery of this NBE Accredited Institution is recognized by the National Board of Examinations, for training of DNB (Rural Surgery) trainees, vide its letter No. _____ dated _____ for ___ number of seats each year and valid up to _____ (month & year).
2. Also certified that Dr. _____ has been selected as a DNB trainee for the _____ session and will undergo training in DNB (Rural Surgery) for a period of 3 years w.e.f. _____ (day) _____ (month) _____ (year).
3. He / She will be writing his / her Thesis under Dr. _____ who is a Senior Post Graduate Faculty of this Institution.
4. Dr. _____ will be maintaining a log book.
5. He / She will be completing his / her training on _____ (day) _____ (month) _____ (year).

SIGNATURE OF THE HEAD OF THE DEPARTMENT
(With seal and date)

SIGNATURE OF THE HEAD OF THE INSTITUTION
(With seal and date)

Annexure 1

Details of Advertisement

1. Date of Publication
2. List of Newspapers where published
3. Last date for inviting applications
4. Annexed copy of advertisement
5. Any other means by which advertisement/admission notice was published like website, notice board, letter to other hospitals etc.

Annexure 2

Format for furnishing details of all applicants

| S.No. | Speciality | Name of all applicants | Educational Qualification | Contact Number like Telephone No., Fax, e-mail, Mobile No. | Date of submission of Application Form |
|-------|------------|------------------------|---------------------------|--|--|
| | | | | | |

Annexure 3

Details of methodology for selection process (Speciality wise)

- (1) Whether the proposed scale for Aptitude Assessment Test issued by the National Board of Examinations has been used or some other methodology has been used (Yes/No)
- (2) If no, given details of the admission process adopted.
- (3) Describe how confidentiality was maintained in the conduct of Aptitude Assessment Test.
- (4) Whether any mechanism was used to screen candidates for the purpose of appearing in Aptitude Test (Yes/No)
- (5) If yes, the methodology so adopted
- (6) Details of scoring methodology used for Aptitude Assessment Test.

Annexure 4

Composition of Selection Committee

| S.No. | Speciality | Name of Selection Committee members | Designation | Name of the Institution where working | Contact Details | Educational Qualification |
|-------|------------|-------------------------------------|-------------|---------------------------------------|-----------------|---------------------------|
| | | | | | | |

Annexure 5

Individual declaration by Selection Committee members (Speciality wise)

I, _____ (Name), working as _____ (Designation), _____ (Hospital/Medical College) worked will be conducting the Aptitude Assessment Test for selection of DNB candidates in the specialty of _____ for _____ (session January/July, 200) for _____ Hospital.

I have examined the list of candidates appearing for the said Aptitude Test and hereby certify that none of my blood relatives or near relatives (son-in-law/daughter-in-law, son/daughter, niece, nephew or any other dependent/progeny) of my family or immediate family (brother, sister, brother-in-law, sister-in-law) are appearing in the said aptitude test. I further certify that none of the candidates is a blood relative or close relative (son-in-law, daughter-in-law) of the promoter/owner/any consultant working in this Hospital.

I also certify that I do not know any candidate by virtue of his parents/family members, etc., (other than professional working experience).

(Dr _____)

Annexure 6

Format for furnishing information of scoring in Aptitude Assessment

| S.No. | Speciality | Name of Candidates assessed | Educational Qualification | Contact Number like Telephone No., Fax, e-mail, Mobile No. | Date of submission of Application Form | Marks Obtained |
|-------|------------|-----------------------------|---------------------------|--|--|----------------|
| | | | | | | |

(Medical Superintendent/ Director ___Hospital)

Annexure 7

Scale for Assessment of Aptitude of candidate

Name of Candidate _____

Specialty _____

| S. No. | Item | Max. Marks | |
|-----------------------------------|---|------------|--|
| A. | Knowledge about Clinical Procedures, Surgical Skills, aptitude, Commonly Practiced Protocols in the concerned specialty. | 10 | |
| 1. | Awareness about the specialty concerned; Is the candidate aware about the commonly practiced clinical procedures relevant/applied to the concerned specialty and the scope of specialty? | 5 | |
| (a) | <i>Not Aware – 0 Marks</i> | | |
| (b) | <i>Somewhat Aware – 2 Marks</i> | | |
| (c) | <i>Aware to a reasonable extent – 3 Marks</i> | | |
| (d) | <i>Possesses sound knowledge – 5 Marks</i> | | |
| 2. | Assessment of candidate for aptitude, commonly practiced protocols, knowledge of applied basic sciences, applied broad specialty to the subject. | 5 | |
| (a) | <i>Aptitude & Knowledge – Nil</i> | | |
| (b) | <i>Aptitude & Knowledge – Reasonable 2 Marks</i> | | |
| (c) | <i>Aptitude & Knowledge – Above Average 3 Marks</i> | | |
| (d) | <i>Sound Knowledge & Definitive Aptitude – 5 Marks</i> | | |
| B. | Experience and Academic Achievement, publication and conference attended. | 10 | |
| 1. | Experience in the concerned specialty | 5 | |
| (a) | <i>Does not possess any experience – 0 Marks</i> | | |
| (b) | <i>Possess some experience in the concerned specialty/allied specialty (has observed procedures/skills), experience less than a year – 2 Marks</i> | | |
| (c) | <i>Possess experience in the concerned specialty (has assisted procedures in the specialty), experience 1-2 years - 3 Marks</i> | | |
| (d) | <i>Definitive experience (independently carried on procedures), possesses at least 2 years of valid experience in the specialty/allied specialty – 5 Marks</i> | | |
| 2. | Academic achievement/publications and conference attended | 5 | |
| (a) | <i>Does not possess any Academic Aptitude – 0 Marks</i> | | |
| (b) | <i>Possess Academic Aptitude – 2 Marks (Evidence attended at least one conference/CME in sub-specialty concerned)</i> | | |
| (c) | <i>Possesses academic aptitude, is aware about recent publications and has attended at least two conferences in the concerned specialty – 3 Marks</i> | | |
| (d) | <i>Sound Academic Aptitude - Attended at least 3 CME/Conference in the specialty – 5 Marks</i> | | |
| TOTAL MARKS (A+B) | | 20 | |
| Marks obtained (out of 20) | | | |
| Rank in Merit List | | | |

Signature of the Head of the Institution

Signature of the Head of the Selection committee

Annexure 8

Offer letter issued to the selected Candidate along with detailed terms and conditions of the Training

- Kindly Annex offer letter of selection and appointment as DNB Trainee issued to the candidate along with comprehensive guidelines and terms and conditions of training, fees charged, facilities provided to the candidates.
- This letter/all documents shall be comprehensive in nature and there shall be no documents other than this which is to be given to the candidate for scoring his admission.

Annexure 9

Declaration Form of the Head of Institution

(This undertaking is to be submitted on Rs.ten non-judicial stamp paper, duly notarized)

I, _____ working as _____ (Head of Institute) of _____ Hospital hereby certify that:

- (i) The information enclosed along with as contained in Annexures 1 to 9 is true to the best of my knowledge and nothing thereon has been concealed.
- (ii) That this institute has not charged any kind of capitation fees/security money/caution money/bank deposit/material security/ fees other than prescribed by National Board of Examinations in any format or any such article/instrument from the candidates towards joining the DNB programme.
- (iii) I undertake that, if this institute/hospital is found not adhering to any of the guidelines of National Board of Examinations, the accreditation of the institute/hospital will be deemed to stand cancelled forthwith.
- (iv) That the selection of DNB trainees has been done as per the guidelines prescribed by the National Board of Examinations.
- (v) That all the candidates have been treated alike on equal grounds and no special privilege or weightage has been given to any candidate on any ground.
- (vi) That the Certificates and Documents submitted by the trainee(s) have been verified from their original degrees and supporting documents and have found to be authentic.
- (vii) That this hospital has maintained a waiting list as per merit obtained by the candidates in this Aptitude Test and any further vacancies arising due to any selected candidate not joining the seat or leaving the seat, the same shall be filled amongst the waitlisted candidates in order of merit. That none amongst the promoters/administrators of the hospital have been associated with the Aptitude Assessment Test and none of their relatives or close contacts have appeared in the Aptitude Assessment Test.
- (viii) The panel of experts for the Aptitude Assessment Test had 50% of experts who are not associated with this hospital in any capacity and have never been associated with this hospital.
- (ix) I undertake that this institution is abiding by the guidelines of the Board for payment of stipend to DNB trainee resident doctors; fees guidelines issued by the Board and will ensure strict compliance of the same for all DNB trainee resident doctors.

Verified and Certified for above.

(DR _____)
MS/ Director
--- Hospital

