ANNEXURE II-A

APPLICATION FORM

FOR VISITING CONSULTANTS (DERMATOLOGY)

(To be sent in a sealed cover mentioning-'EOI for Empanelment of Visiting Dermatology Consultant at KAPS Hospital' to: Medical Superintendent, KAPS Hospital, P.O: Anumala, Via: Vyara, Dist.: TAPI – 394 651, Gujarat)

(Kindly fill up all the columns. Incompletely filled form will not be considered)

Advertisement Notice No.	: EOI NO. KAPS/EOI/HR-HOSPITAL/2021/04	Photograph
Name of the Post	: **VISITING DERMATOLOGY CONSULTANT**	
1. Applicant Full Name (In Capital Letters)	: Dr. _____	
2. Age & Sex	: _____ years, Male / Female	
3. Address	:	
4. Mobile No.	:	
5. e-mail Address	:	
6. Medical Qualifications	:	
7. Registration Number	:	

8. Medical Qualification details -

Sr. No.	Exam Passed	Name of College / University	Year of passing	Duration of course
1				
2				
3				
4				

9. Total Years of post qualification Experience: _____ years

10. Experience Details (starting from present/ last employment):

Sr. No.	Name of the Employer	Post Held	From Date	To Date	Total	
					Year	Month

1						
2						
3						
4						

11. Whether attached to KAPS Empanelled Hospital.	YES / NO	**If YES**, please provide the Name & Address of KAPS Empanelled Hospital :-
12. Whether served at KAPS hospital as consultant earlier.	YES / NO	**If YES,** details thereof -
13. Frequency of Visit	: **Once in a week for two hours**	
14. Convenient time (Preferably between 09:00 am to 07:00 pm)	: _____ to _____	
15. Consultation Charges as per CGHS Rates per visit (for up to 20 patients) acceptable.	**YES / NO**	
	If NO , then - Expected remuneration per visit: - Rs. _____ per visit (for up to 20 patients)	
16. CGHS Rates on Minor Dermatology procedures acceptable at KAPS Hospital.	**YES / NO** **Note-** Negotiation on CGHS Rates will be carried out during the process of empanelment for operating minor Dermatology procedures at KAPS Hospital.	
17. Expected Transportation charges per visit	: Rs. _____per visit.	
18. Expected consultation charges per patient (beyond 20 patients)	: Rs. _____ per patient.	
19. Period of Contract	03 (Three) years.	

Date :

Signature :

Name :

ANNEXURE II-B

QUALIFICATION CRITERIA FOR VISITING CONSULTANTS

(DERMATOLOGY)

1.	**Educational Qualification –**	MBBS and MD (Dermatology) **OR** MBBS and DNB in Dermatology **OR** MBBS and Diploma in Dermatology
2.	**Experience in relevant field –**	Minimum 5 years.
3.	**Document to be enclosed along with Application form –**	i. Photo I/D issued by any Govt. Authority. ii. Address proof (Driving license, Voters card, etc.) iii. Degree certificates. (MBBS & Post-Graduation) iv. Experience certificate in relevant field issued by employer / institution. In case of Private Practice, **self declaration** of experience in relevant field on Letterhead should be enclosed **in attached format (ANNEXURE II-C)**. v. Registration Certificate for Additional Medical Qualification (Dermatology) issued by State/Central Medical Council.

Note:-

- Only eligible candidates who meet the above qualification criteria should apply for this post.
- Candidates having higher qualifications and experience will be preferred for empanelment.
- Above post is purely on contractual basis and will be adhered to the terms & conditions of contract agreement to be signed between KAPS & Visiting Consultant.

- **Indicated Consultation Charges:-**
  a) Diploma holder with 05 years experience – on CGHS rates.
  b) Diploma holder with 10 years experience – 1.5 times of CGHS rates.
  c) Post Graduate/DNB Degree Holder with 5 years experience – 1.5 times of CGHS rates.
  d) Post Graduate/DNB Degree Holder with 10 years experience – 2.0 times of CGHS rates.
  e) DM/MCH Holder - 2.5 times of CGHS rates.

ANNEXURE II-C

SELF DECLARATION OF EXPERIENCE ON LETERHEAD

(To be submitted by visiting consultant in case of private practice)

I, Dr_____, hereby declare that I am a Registered Medical Practitioner (RMP), practicing at my Private Hospital/ Clinic at the address mentioned below since last _____ years.

I also hereby declare that I have gained the sufficient clinical experience in my discipline / specialty during the above period.

Name & Address of Private Hospital/ Clinic	:
Contact No.	:

Date :

Signature :

Name :