Sri Ramachandra Medical Centre
Department of Reproductive Medicine and Surgery

The Department of Reproductive Medicine and Surgery, Sri Ramachandra Medical Center is pleased to announce the admission to Fellowship Programs in Reproductive Medicine.

Course Details: **Fellowship in Reproductive Medicine**

- **Qualification** : MS/MD (OB-GYN) / DNB(OB-GYN)
- **Number of Seats** : 4
- **Course Duration** : 12 months
- **Course Fee** : Rs. 7,50, 000/- (Rupees Seven Lakhs and fifty thousand only)
- **Stipend** : Rs. 12,000/- per month (Rupees Twelve thousand only)
- **Attendance requirement for examination** : 90 %

Those interested may kindly submit the prescribed application form to below @ address.

- Last Date for submitting Application 5th February 2024
- Written Test and Interview will be 3rd week of February 2024
- Course commences 1st week of April 2024

For downloading application – Click on Fellowship in Reproductive Medicine.

Address for Communication:
HOD - Reproductive Medicine and Surgery
E2 – II, SMART,
Department of Reproductive Medicine and Surgery,
Sri Ramachandra Medical Centre,
No. 1 Sri Ramachandra Nagar, Porur, Chennai 600116

For further information if any please call 044-45928510
Email Id : fellowship.mc@sriramachandra.edu.in
Website : www.sriramachandra.edu.in

SRI RAMACHANDRA MEDICAL CENTRE
Porur, Chennai - 600 116.

APPLICATION FORM FOR "FELLOWSHIP IN REPRODUCTIVE MEDICINE" 2024-25 Session

Affix your latest colour Passport size photograph here.

(**Note**: Please fill in each column in your own handwriting and put a tick mark (√) wherever necessary and strike off the portion not applicable. Incomplete application form will be rejected summarily).

1. a) Name of the candidate (AS PER PROVISIONAL / DEGREE CERTIFICATE IN BLOCK LETTERS)	:	Dr.
b) Expand the initials	:	
c) Complete address (with District, State & PIN CODE) to which communication is to be sent	:	
d) Phone No. with STD Code	:	Residence : Mobile : E-mail ID :
2. a) Father's Name Contact Details	: :	Mobile : E-mail ID :
b) Mother's Name Contact Details	: :	Mobile : E-mail ID :
c) Husband's Name Contact Details	: :	Mobile : E-mail ID :
3. Sex	:	Male ☐ Female ☐

4. a) Date of birth and age	:	DD/MM/YYYY	Age:
b) Place of birth, District and State	:		
5. Qualifying examination passed. (Self attested Photocopy of the Degree certificate and Statement of Marks of all examinations to be enclosed)	:	Name of PG Degree : University Regn. No : Month : Year :	
6. a) Name and address of the Medical College where qualified	:	UG …… …… PG …… ……	
b) Whether the College and course is Recognized by the Medical Council of India.	:	Recognised	Not Recognised
7. Experience Details			

8. a) Papers Presented :

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b) Papers Published :

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9. a) Whether the candidate has passed all the examinations in the first attempt	:	PG : Yes / No MBBS: Yes / No
b) If no, how many attempts were made to pass	:	<table><tr><th>Course</th><th>No. of attempts</th></tr><tr><td>MBBS</td><td></td></tr><tr><td>PG</td><td></td></tr></table>
10. Details of Permanent Registration with the Medical Council incorporating PG qualification (Photocopy to be enclosed)	:	State : Regn. No.: Date :

DECLARATION BY THE CANDIDATE

I declare that the information furnished by me herein are true and correct. In case any information furnished herein is found to be incorrect or any document is found to be not genuine, I agree to forego my claim for admission and abide by the decision of the Sri Ramachandra Medical Centre authorities.

I further declare that I have read the prospectus furnished with the application form fully and understood the contents therein clearly and I hereby undertake to abide by the conditions prescribed therein. I undertake to abide by the Rules and Regulation of Sri Ramachandra Medical Centre.

Place: Signature of the Candidate

Date: Name: