SRI RAMACHANDRA
MEDICAL CENTRE

Department of Radiology and Imaging Sciences

The Department of Radiology and Imaging Sciences, Sri Ramachandra Medical Center is pleased to announce the admission to Fellowship Programs in

Cross sectional Imaging.

<u>**Course Details:**</u>
<u>**Fellowship in Cross Sectional Imaging**</u>

Qualification : MD / DNB (Radiology)

Number of Seats : 1 (Jan Session)

Course Duration : 12 Months

Course Fee : Rs.1,50,000 (Rupees One Lakh Fifty thousand only) **Stipend : 1 –**

6 months – No Stipend

7 - 12 Months – Rs.12,000 (Rupees Twelve thousand only)

Training timings : 8.00 am to 5.00 pm; Two short calls per week (4-8PM)

Attendance Requirement for examination : 90%

Those interested may kindly submit the prescribed application form to below address
  ☐ Last date for submitting Application **6 th Nov 2023**

  ☐ Written entrance test & interview will be on **18th Nov 2023 at SRMC**

  ☐ Course commences on **3rd Jan 2024**

Address for communication :
 The Medical Director
 Sri Ramachandra Medical Centre
 Porur, Chennai – 600 116.
 Phone – 044 – 45928552 (8 to 4 pm)
 OR
 Head of clinical services (HOCS)
 Department of Radiology and imaging sciences
 Sri Ramachandra Medical Centre
 Porur, Chennai – 600 116.
 Phone – 044 – 45928625 (8 to 4 pm)

SRI RAMACHANDRA
MEDICAL CENTRE

DEPARTMENT OF RADIOLOGY AND IMAGING SCIENCES

APPLICATION FORM 2024 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 not be accepted).

1. Cross sectional imaging (12 Months) 4. MSK Imaging (6 Months) 2. Basic breast imaging & interventions (6 Months) 4. 5. PET CT Imaging (6 Months) 3. Advanced breast imaging & interventions (12 Mon)

(Please give two choices in the order of preference)

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. Gender		Male Female

1

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 ecognized by the Medical Council of India.	:	Recognised	Not Recognised	
7. 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	:	Course No. of attempts MBBS PG	
8. Details of Permanent Registration with the Medical Council incorporating PG qualification (Photocopy to be enclosed)		State : Regn. No.: Date :	

9. a) Papers Presented:

…………………………………………………………………………………………
……………

…………………………………………………………………………………………
……………

…………………………………………………………………………………………
……………

…………………………………………………………………………………………
……………

…………………………………………………………………………………………
……………

…………………………………………………………………………………………
……………

…………………………………………………………………………………………
……………

2

b) Papers Published:

……………………………………………………………………….……………
…………
……………………………………………………………………….……………
…………
……………………………………………………………………….……………
…………
……………………………………………………………………….……………
…………
……………………………………………………………………….……………
…………
……………………………………………………………………….……………
…………
……………………………………………………………………….……………
…………

(if necessary attach separate sheet)

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:

Submit Application online (with attachments) to:

The Medical Director, Sri Ramachandra Medical Centre, Porur, Chennai – 600

116. fellowship.mc@sriramachandra.edu.in