NOTIFICATION

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.

Course Details:
Fellowship in Cross Sectional Imaging

Qualification	**:** MD / DNB (Radiology)
Number of Seats	: 1 (Jul Session)
Course Duration	: 6 Months
Course Fee	: Rs. 75,000 (Rupees Seventy five thousand only)
Stipend	**: 1 – 3 months – No Stipend**
	4 – 6 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%

- Last date for submitting Application **12th May 2024**
- Written entrance test & interview will be on **23rd May 2024 at SRMC**
- Course commences on **1st July 2024**

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

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)

Website: www.sriramachandra.edu.in (Medical Centre)
email: fellowship.mc@sriramachandra.edu.in

SRI RAMACHANDRA MEDICAL CENTRE

Porur, Chennai - 600 116.

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 (6 Months) ☐ 2. MSK Imaging (6 Months) ☐

3. Basic breast imaging & interventions (6 Months) ☐ 4. PET CT Imaging (6 Months) ☐

(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 : Mob : E-mail ID :
2. a) Father's Name Contact Details	: :	Mob : E-mail ID :
b) Mother's Name Contact Details	: :	Mob : E-mail ID :
c) Spouse 's Name & Contact Details	: :	Mob : E-mail ID :
3. Gender	:	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.	:	Recognized	Not Recognized
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: MBBS, PG No. of attempts:	
8. Details of Permanent Registration with the Medical Council incorporating PG qualification (Photocopy to be enclosed)	:	State : Regn. No.: Date :	

9. a) Papers Presented:

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b) Papers Published:

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(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 :