Indian Society of Critical Care Medicine

Indian College of Critical Care Medicine

Exam Form

Indian Fellowship in Critical Care Medicine

Date of Examination: **Practical: October, 28th or 29th, 2017 (any one day)**

Fresher/Repeater: _____

Candidate Name: _____

Name of the Institute: _____

Name of the teacher: _____

Kindly submit the scanned copy of this exam form, by 30th September 2017, at the following email ids: education@isccm.org & executive_college@isccm.org

If this form is not submitted by the last date mentioned above, you will not able to appear for the exam. Examination center shall be allotted by the college only after the receipt of this form

Request for change of venue or date of exams shall not be accepted in any circumstances.

Note:
Fees once paid is non-refundable and not adjustable for next attempt after submission of Exam Form
Incomplete forms will not be accepted and all have to compulsory submit the project report/ completed log book along with form.

Address of candidate: _____

_____City_____

State: _____Pincode:_____

Email: _____Mobile:_____

Date of Joining the Course: _____

Date of Completion of Course: _____

Fee Details if repeater (If applicable: Cheque/DD no._____Date_____

(Signature of candidate)

Please note that if you are appearing for the first time in the exam, you should complete the form your teacher should complete the **SECTION I** and the hospital administrator should complete **SECTION II**. Repeat takers are not required to complete SECTIONS I & II, but should make a self-declaration on the courses attended.

SECTION I

Completion Certificate

I confirm that Dr. ……..

has completed/likely to complete the requisite training at ……

From …… / ……/ …… to ……/……../……

and also attended the following Workshops during his / her training.

Sr. No.	Workshop	Date	Venue	Attended YES/NO
1	Advanced Cardiac Life Support (ACLS)			
2	Mechanical Ventilation			
3	4C Course			
4	Refresher Course			
5	Haemodynamic Monitoring			
6	Others			

(Note: Kindly attach the photocopy of workshop certificate attended)

_____

Name & Signature of Teacher Date

SECTION II

I certify that Dr …….. has completed/likely to complete

one year training in our Institution, namely ……

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From …. /…../…….. to …. /…../…….. , in Department of Critical Care Medicine

Signature of MS/MS/CEO of the Institution with Seal