

FOR FELLOWSHIP/CERTIFICATE COURSE(S) FOR A.Y. 2026 -2027

(As per provisions of the Maharashtra University of Health Sciences Act, 1998 and University Rule / Guidelines)

Date of Inspection	:	
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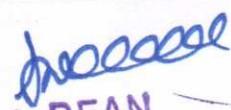
1. Name(s) of the Fellowship/Certificate Course(s)

Sr. No.	Name of the Fellowship/Certificate Course	Course Started from the Academic Year	Intake Capacity Sanctioned by the University	Name of Mentor and Contact Details
01				
02				
03				
04				
05				
06				
07				

(Attach separate List if necessary)

2. Year-wise number of students admitted to Fellowship / Certificate course during last 5 years

Sr. No.	Academic Year	Name of Fellowship / Certificate Course	Intake Capacity	No. of Students Admitted (In figure only)
1	A.Y. 20..... - 20.....			
2	A.Y. 20..... - 20.....			
3	A.Y. 20..... - 20.....			
4	A.Y. 20..... - 20.....			
5	A.Y. 20..... - 20.....			


DEAN
 Dr. Shankarrao Chavan Govt.
 Medical College, Vishnupuri, Nanded

Information to be submitted with respect to newly appointed mentors

**Professional Teaching Experience Certificate for
Fellowship/Certificate Courses
Director/Mentor**

Title of the Course applied for:-
.....

This to Certify that
Dr

has
worked in the Department of Training

C

entreasper following details

A) General Experience

Designation	From	To	Total periodYear/Months	
		N/A		

**B) Actual experience in the subject of concerned
Fellowship/Certificate Courseapplied for :-**

Designation	From	To	Total periodYear/Months	

(It is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in theSubjectof concerned Fellowship/Certificate Course)

Sign & Stamp
Head of the Department

ad of Institute
Date : / /

Sign & Stamp

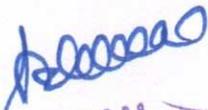
Dean/Principal/He

Date: / /


DEAN
Dr. Shankarrao Chavan Govt.
Medical College Vishnupuri, Nanded

Name of Inspectors		Signature of Inspectors
1)	Chairman	
2)	Member	
3)	Member	
4)	Member	

N/A


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