GOVERNMENT OF TRIPURA
OFFICE OF THE PRINCIPAL
AGARTALA GOVERNMENT MEDICAL COLLEGE
e-mail : agmc@rediffmail.com / agmc.academic@gmail.com

Comp.No.161458

No.F.4(5-286)-AGMC/Academic/ICC/24 Dated, Agartala the 1/09/2025.

N O T I F I C A T I O N

Subject: Availability of CRMI Log Book from next Session i.e. 2026–27 onward.

All concerned are hereby informed that the **Log Book** for the Compulsory Rotating Medical Internship **(CRMI)** from the upcoming session i.e. from **2026–27** onward will be made available in **softcopy (.pdf) format** on the website of this institute https://www.agmc.ac.in/

The printed Log Book must be brought on the **first day of internship training** and maintained throughout the internship period as per the prescribed guidelines.

Duly filled-up & signed **Log Book** of 104 pages along with **No-Duse & Completion Certificate** (FORMAT enclosed) must be submitted to the office of the undersigned immediately on completion of CRMI.

For further details or updates, please refer to the website or contact with Academic Section of this institute.

Signed by Dr.anup Kumar Saha
Date: 03-09-2025 16:59:50

Principal, AGMC

To,
All the MBBS 3rd Prof. Part-II passed out students for information and necessary action.

Copy for information to:
1. The Director of Medical Education, Govt. of Tripura.
2. The Vice Principal cum Chief Medical Superintendent, AGMC & GBPH.
3. The Dean (Academics), Agartala Govt. Medical College.
4. The Medical Superintendent & HoD, AGMC & GBP Hospital.
5. The Dy. Director (Admin) & HOO, O/o the Medl. Supdt., AGMC & GBP Hospital.
6. The Dy. M.S.(GA/MCP/RKS), AGMC & GBP Hospital.
7. The Nodal Officer (IT), AGMC & GBP Hospital with a request to arrange to upload the notification along with soft (.pdf) copy of the CRMI Log Book (enclosed) to our official website, which may be download by any one as and when required.
8. NOTICE BOARDs.

AGARTALA GOVERNMENT MEDICAL COLLEGE & GBP HOSPITAL

No Dues Cum Completion Certificate

Consequent upon completion of One Year of Compulsory Rotating Medical Internship (CRMI) Session: _____ of Dr. ....., MBBS Student of Batch: _____, concerned HoD / IcHoD, Librarian, Hostel Superintendent and In-Charge of Accounts Section, AGMC are requested to issue the **No-Dues Certificate** at the earliest to process the case further. It may be mentioned that leave taken in excess of the leave admissible may be compensated by the Intern before the issuance of the No-Dues Certificate. The Concerned HoD may forward extension for the intern for the respective departments.

Sl. No.	Name of the Department	Leave taken as per performance certificate/application received	No Due/Dues/ Remarks	Signature with Seal of HoD / I/cHoD / MOIC
1	Community Medicine			
2	General Medicine			
3	Psychiatry			
4	Paediatrics			
5	General Surgery			
6	Anaesthesiology & Critical Care			
7	Obstetrics & Gynaecology including F.W. & Planning			
8	Orthopaedics including PM&R			
9	Emergency / Trauma / Casualty			
10	Forensic Medicine & Toxicology			

Contd..... P/2

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Sl. No.	Name of the Department	Leave taken as per performance certificate/application received	No Due/Dues/ Remarks	Signature with Seal of HoD / IcHoD / Librarian / Hostel Super./Accountant
11	Dermatology			
12	Otorhinolaryngology			
13	Ophthalmology			
14	Elective (AYUSH)			
15	Elective (Radiology)			
16	Elective (Respiratory Medicine)			
17	Hostel	--		
18	Library	--		
19	Accounts Section	--		

After completion by all the Departments, the **No Dues Certificate** is to be returned to the office of the Principal, AGMC for further necessary action.

Dean(Academics)
AGMC

AGARTALA GOVERNMENT MEDICAL COLLEGE

LOG BOOK

COMPULSORY ROTATING MEDICAL INTERNSHIP (CRMI) as per NMC Regulations,2021

Intern's Name: .....

ID No. : ..... **Session:** .....

Details of the Intern Doctor:

Affix Recent
Pass-Port size
Photograph

Name: .....

Father's Name: .....

Permanent Address : .....

.....

.....

Phone & WhatsApp No.: .....

E-mail ID : .....

Date of Admission in the Course(MBBS) : .....

Final University Examination
(MBBS, 3rd Professional, Part-II) Result Published on :.....

TSMC's Provisional Reg. No.: .....

ID No.: ..... Session: .....

CRMI Scheduled From: ..... To .....

CRMI Started on : ..... Completed on : .....

Signature of Intern

Signature of Dean with Seal

Examination	Subjects	Date of passing
MBBS 1st Professional	Anatomy	
	Physiology	
	Biochemistry	
MBBS 2nd Professional	Pathology	
	Microbiology	
	Pharmacology	
MBBS 3rd Professional Part I	Community Medicine	
	ENT	
	Eye	
	FMT	
MBBS 3rd Professional Part II	General Medicine	
	General Surgery	
	Obst. & Gyanecology	
	Paediatrics	

Signature of the Intern

Signature of Principal

Note :

- This is an Important Document.
- Preserve it carefully.
- Deposit it in the office of the Principal, AGMC.

EXPLANATORY NOTE

This Internship training programme broadly includes demonstration and applied basic sciences, bedside clinics, case presentation, symposium / seminars inter departmental discussion and guided clinical responsibility.

It is essential that the fresh Indian Medical Graduate (IMG) maintains a meticulous account of work done by the concerned Intern. The log book is an important document and integral part of training program. It will be part of trainee's assessment and will be required for Future evaluation for different purposes. The log book will form basic for issuing experience after completion of his/her tenure in the department.

The log book is divided into numbered segments corresponding to the internship training program. The trainee is required to fill it up regularly and the entries need to be endorsed by the concerned faculty / HODs.

On the completion of the Internship by the candidate, the log book shall be deposited in the principal's office for future references.

PREFACE

This booklet is being presented with an intention to streamline the working of the interns. Internship is an important period in a doctor's career. During this period many skills are learnt and the knowledge and skills acquired during training are consolidated. A proper attitude by the intern and good guidance by the supervisors inducts and orientates the Fresh Indian Medical Graduate (IMG) into the Medical professional life.

Agartala Government Medical College is recognized in stature by the quality of knowledge and skills imparted at the Indian medical graduate and Post-Graduate level. Care has been taken to impart competency based training during internship. Education and Training and to transform the theoretical knowledge acquired during the four and a half year of theoretical teaching to its clinical application for a better understanding of the subject. An attempt will simultaneously be made to prepare the fresh interns for their forthcoming Entrance Examinations for admission to postgraduate courses. Besides, it is also aimed to acquire basic skill of communication for proper interaction with patients and their attendants, Para-medical staff in a polite and dignified manner.

Professional Competence is demonstrated by judicial use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served. Thus adherence to ethical principles and sensitivity to a diverse patient population is foremost.

Knowledge and skill is the platform on which the art of medical practice will be based. The intern must then synthesize the science and art to create a smooth process in which the two are closely intertwined.

"A doctor is a student till his death, when he fails to be a students, he dies." (Sir William Osler)

I wish all interns an exciting and fruitful internship period.

Principal
Agartala Govt. Medical College

GENERAL GUIDELINES FOR INTERNSHIP

1. Before starting Internship the Intern must have provisional Registration certificate form state medical council.
2. After the posting orders are issued by the Principal's Office, the Intern must report to the concerned Head of the Department first, who will give the unit postings.
3. The Intern must attend the postings regularly and maintain punctuality.
4. On the first day of the postings itself, the Intern must obtain the Unit Heads / Staff / In-charge signature at the appropriate place in the Log Book.
5. On completion of the postings, the Intern must get the unit Head's signature on the last day itself and never postpone it. Subsequently the Intern must obtain the Completion Certificate from the H.O.D immediately thereafter.
6. The Intern must sign the attendance register daily at the proper time either in the Unit Head's office of Department office.
7. Leave cannot be availed under any circumstances during Internship.
8. Wearing of apron with name plate is compulsory during duty hours. They should get a rubber stamp made and always use wherever they sing.
9. The Interns should carry the stethoscope, Knee hammer, Tape measure and other accessories for examining the patient in a small bag.
10. On completion of all the posting, the Log Book complete in all respects including the Certificate of Completion (print in the Log Book itself) from each department duly signed by the H.O.D must be submitted to the Principal Office, for issue of Internship completion certification.
11. For any extension of posting, fresh posting orders must be obtained from the H.O.D of the Principal Office.
12. Internship shall not be started without the Log Book.
13. The Log Book contains the record of work done by the Intern and must be signed by appropriate authority.
14. The nature of duties of be performed by the Intern during the training pertains to either the minimum required by MCI or that prescribed by the H.O.D The Intern must abide by these.
15. All parts of Internship should be bone in MCI recognized hospitals within Indian.
16. The total duration of Internship is ONE YEAR(365 days)
17. The Interns have no authority to issue a death certificate or sign a medico legal Document.
18. Attendance at the INTERN'S ORIENTATION PROGRAMME is compulsory.

Principal
AGMC & GBP Hospital

GENERAL INSTRUCTIONS

Internship is a phase of training wherein a graduate is expected to conduct actual practice of medical and health care and acquire skills under supervision so that he/she may become capable of functioning independently.

In order to make workforce available, it may be considered as a phase of training where in learning methods and modalities have to be done during the MBBS course itself with lager number of hands on session, practice on simulators including.

DUTIES OF THE INTEREN

Obtaining information about his / her patients and communicating such information to appropriate persons are two of the main duties of Interns. As the Intern of the spot, at times he/she takes up his/her appointment, the Intern should visit all the principal departments, and should find out from his/her predecessor, or other colleagues, who are the most helpful members in the various departments.

Specific objectives:

(i) Diagnose and manage clinically common disease conditions encountered in clinical practice and make timely decision for reference to higher lever.
(ii) Use discretely drugs, preferably generic as per MCI guidelines, infusions bold or its substitutes and laboratory services.
(iii) Able to Prescribe rationally as per clinical situation.
(iv) Manage all type of emergencies – Medical, Surgical, Obstetrics, Neo-natal and Pediatrics.
(v) Monitoring the National Health Programme and schemes, oriented to provide Promotive, preventive, curative and rehabilitative health care services to community.
(vi) Render services to chronically sick and disable (both physical and mental) and to communicate effectively with patients and community.
(vii) Acquire adequate communications skills for proper interaction with
    (a) Patients and Attendants
    (b) Seniors
    (c) Peer Group
    (d) Other Para-medical Workers.
(viii) Acquire ability, to judiciously select appropriate investigations as per clinical situation, properly collect samples for analysis and to interpret common clinical and laboratory data.
(ix) To carry out day to day ward procedures and treatment.
(x) To fill appropriate hospital forms and certificates.
(xi) To be able to identify adverse drug reaction and able to fill up ADR form and report the same in ADR monitoring center under PvPI.

Decorum

The old-fashioned word is used to remind the new interns that if he / she want to be treated as a doctor, he / she should look behave like one, Dirty, polo-necked sweaters and long, unkempt hair are not acceptable in either place. A clean white coat always looks professional. It is safer to carry and use a notebook, rather than rely on memory. When talking to patients and relatives it is advisable to keep the conversation professional, but using simple words that are readily understood.

With some elderly patients it may be necessary to use a local dialect to obtain accurate information, but in general gimmicks are better avoided.

If he / she is wise, an intern can learn a great deal from these permanent members if the surgical team, from the physiotherapist, pharmacist, head porter and other personnel who keep a modern hospital functioning smoothly.

Smoking

Smoking is dangerous to health, and doctors should set an example to the public by not smoking. A resident / intern should never smoke in front of patients, or in parts of the hospital where he may be seen by members of the public.

Time Keeping

Patients in an acute surgical / medical ward need to have a doctor readily available at all times. One of the first tasks of a new intern is to check up in detail on the suggested duty or off-duty rotation in his / her hospital. He / she has to make certain that there is continuous medical cover for his patients, 24 hours per day, 7 days per week. Consultation with other colleagues usually enables a safe and satisfactory rotation to be worked out. When on duty the doctor should endeavor to be punctual. This usually means being in the ward one hour before the consultant is expected, so that the latest state of the patients may be ascertained. Reliability and punctuality are major factors in a young doctor's chances of promotion.

If for any reason he / she has to absent himself from the usual place of work while on duty, the intern should inform the ward sister and hospital telephonist exactly where can be quickly contacted in an emergency.

Responsibility and consultation

If he / she is ever in doubt about a ward technique of how to proceed, the intern should ask a more senior doctor for advice and help that is how an apprenticeship system works. The young doctor should know his /her limitations, without at the same time allowing himself / herself to become a nuisance to other.

The faculty / consultant in charge will generally want to know at once of any unusual happening in ward / emergency such as sudden death, unexpected complication, threatening relatives or anything that may lead to litigation later.

Always inform the faculty on duty of any late major changes in the plans made for the next day, for example cancellation of an operation list caused b illness, strikes of staff shortages.

Communication with Nursing and other Staff

Patients sometimes confide in Nurses information which they have been afraid to tell the doctor. Nurses often gain considerable insight into home circumstances, and an experienced nurse may be almost as good as a medical social worker in sorting out the patient's domestic problems. The intelligent intern can learn a lot from the nursing staff.

He / she should always be considerate and polite towards them. Try to avoid interviewing patients in bed at times when nurses are known to be serving meals, dispensing drugs or giving out bed-pans, student nurse appreciate the doctor in the ward explaining a patient's symptoms and treatment to them when time permits.

Communication with relatives

It is not uncommon for relatives to be even more worried than the patient who is admitted to hospital. Consequently they should be handled carefully and with sympathy. This is the doctor's first duty is always to his patients. Sometimes relatives become unreasonable and make a nuisance. That is the time to be firm and to enlist the support of a senior doctor. Always explain the seriousness of the illness to relatives.

Interns must do complete working up of the patients:

- History Taking,
- Examinations,
- Investigations
- Maintenance of Records:
- Skills to develop: Communications, Venipucture, Intravenous infusion, Starting Blood Transfusion, Suturing, Suture Removal, Dressing. Catheterization, Cardio-Pulmonary Resuscitation(CPR) and develop positive attitude to all.

NOTE-TAKING

Good patient records are essential for correct diagnosis and management and for follow-up and research purpose at a later date. They form a useful index of the standard maintained in a surgical / medicine unit, and some institution for higher surgical / specialized training take ward records into account when deciding whether or not a hospital post should be recognized for training purposes. Good records are invaluable for

the preparation of insurance reports and in any legal proceedings. Note about-patients should be written legibly at once and not left until later.

Several systems are in use.

All should include:

(a) Of what include simple statements:

(b) Duration of complaint:

(c) How it began.

It is advisable to record specific dates and times, there may be several different symptoms to be dealt with in sequence.

Has he had any adverse reactions to drugs in the past?

A provisional diagnosis should be suggested after the first round of questions and investigations. At the end of a ward admission the definitive diagnosis in written down, along with the arrangements for after-care. Investigation and diagnosis are conducted in a dynamic and logical manner.

USE AND ABUSE OF LABORATORIES

During the past thirty years, the numbers of laboratory tests and of other special investigations being performed in hospitals have rise alarmingly. Many are totally unnecessary and constitute an unjustifiable waste of scarce health care resources.

Before ordering any test the Interns / Junior doctors should ask himself: On the clinical evidence available, is there any reasonable chance that in this patient this test is going to show an abnormal result?' if the answer is a clear 'yes', the test is performed forthwith, but if the answer in 'no', then the test is no requested at the time, although it may have to be performed later and after further consultation, the art is as important as the science in the practice of good medicine, and common sense is an essential component of both.

Writing on a request form to be sent to a laboratory should be legible. As well as particulars of the patients, the ward number, consultant and date, the form should quote any hospital unit number, mention any similar previous testes(with dates), and relevant drugs that the patient is taking.

It should end with a clean statement of what information the ward or clinic doctor wants from the laboratory.

REQUESTING ANOTHER OPINION

When the surgeon/physician/consultant wants advice from a colleague in another ward or department, first ascertain if that person is available. If the matter is urgent, a personal visit is made to the other doctor and the nature and urgency of the situation explained to him. This is more tactful, factual letter can be delivered by hand to the unit where advice is being sought. It is unwise to rely on important letter reaching the correct specialist by entrusting them to impersonal delivery services. A telephone call can supplement a written communication.

PRESCRIBING DRUGS

This is a task that has to be performed carefully and with attention to detail, particularly when dealing with controlled and other dangerous drugs.

Drug prescription card commence with:

(1) The date and time
(2) The pharmaceutical name /generic name of the drug.
(3) The dose in metric units
(4) The route
(5) The time and frequency of administration, and finally
(6) Sign the entry

WARD ROUNDS

The interns should go round all the patients under his care first thing each morning, checking not only on temperatures and intravenous infusions, but also on such mundane matters as urine output and bowel function.

He / she should note the number of empty beds, particularly if his / her ward is to receive emergency cases that day.

The time of the nursing staff is just as valuable as that of the doctors.

Rounds should not normally be started when meals are about to be served.

If the senior residents are available, they should go round with the junior residents, Interns and not expect the senior nurse to accompany each of them on separate peregrinations. When the faculty goes on round, the interns should have all the case notes and latest result available for inspection and discussion. Before he leaves the ward, the interns must make a clean arrangement with another doctor in the surgical / medical team, or with a colleague in an adjacent ward, to visit his / her ward in the late evening. It is important to tell the senior nurse whom to contact in case of difficulty, and leave a prominent note to this effect nurse go off duty too!.

DISCHAREING A PATIENT

When possible, a patient should be told a few days before it is lively that he / she will be able to leave hospital, He can then tell his relatives and make arrangements. It is very expensive to keep a patient in a hospital bed.

The intern should show intelligent anticipation in each case and try to ensure that very patient gets home to his family as soon as it is medically safe for him to do so. Before the patient leaves the ward, the doctor needs to check on the state on any incision and make sure that the patient is fit to make the journey. A patient should not be sent home to an empty house after an operation.

Patient taking his own Discharge

A patient of sound mind has the right to decide what treatment he will accept ad when he will leave hospital. If the doctor considers it medically unsafe for the patient to leave hospital, he should reason and explain to the patient in front of a witness. The consequences of his action having been explained, if the patient still insists on leaving, he should be asked o sign a form acknowledging that he is leaving contrary to medical advice. This form is duly witnessed.

If the patient refuses even to sing the form, then the doctor and witness sing it, noting down the patient's refusal to accept advice and complete the form. When the patient is considered to be of unsound mind the duty psychiatrist should be called at once.

OPERATING LISTS

Consent:

Each patient having an operation has to sign a consent form after the nature of the operation has been explained to him. The Interns / Junior Resident must give this explanation in simple terms. It is most important that the patient understands what is involved, particularly if a limb or breast is to be removed, an external intestinal stoma established, or the patient rendered sterile.

The patient has to agree that the operative and anaesthetic techniques can be varied as considered necessary, and no undertaking is given that the procedure will be performed by any particular doctor.

CONFIDENTIALITY

Always remember that information gained about a patient is confidential and should only be divulged readily to professional personnel directly concerned with the patient's management.

Be on guard when inquiries are made by employers, lawyers and insurance companies. Ask the patient if he / she wishes them to be told about his / her medical condition, and where appropriate get his / her written consent.

CAUSE OF DEATH (Not to be issued by the Interns)

When the cause of a patient's death is known, the necessary certificate should be issued to the distressed relatives as soon as possible. They should not be kept waiting, the Interns / Junior Resident should leave some less urgent task to complete the certificate. The formalities for recording deaths with central government authorities vary in different part of the world.

The main purpose is to provide accurate information on the causes of deaths within the different countries. Health care resources and research can then be directed towards tackling the principal killing disease.

STILL BIRTH CERTIFICATE (Not to be issued by the Interns)

The definition of a stillborn child a child which has been born after the 28th week of pregnancy and which did not, after having been completely expelled from its mother, breathe or show any other sign of life.

Either is required to have been present at the birth or to have examined the body of the child before coming to an opinion. If the birth was unattended the legal authority should be informed, unless the fetus shoes clear evidence of maceration or of a deformity incompatible with life.

When a fetus is delivered dead before the 28th week of pregnancy, it presumed by law to be non-viable and therefore no legal certificate of any kind is required.

On the other hands, should a child at any stage of pregnancy be born alive, then its birth will have to registered and the usual certificate of death be - completed by the ward doctor regardless of the time that it survived.

EXTERNSHIP

Guidelines for outside candidates wishing to do Internship in AGMC & GBP Hospital :

1. The students may apply if there is a clear cut vacancy in the institution provided the following Certificates / Documents are produced.
   i. Application of the student giving reasons to do internship and documentary proof thereof:
   ii. No objection certificate from his / her parent institution clearly stating that institution is recognized by MCI and that during the course of his / her training from admission to his/ her passing out the college was not derecognized by MCI at any time.
   iii. Permission of the university to which the above college is affiliated.
   iv. Certificate of provisional Registration by MCI.
   v. Certificate of good character and conduct of the student from the patent college.
   vi. (a) The undertaking that the student is prepared to internship without any stipend or honorarium.
   (b) That he/she would maintain good conduct, discipline and decorum and the authority has the right to expel him/ her on misconduct, indiscipline and unsatisfactory work.

SELECTION :

Selection will be strictly on the basis of merit and AGMC Rules.

EVALUATION CRITERIA ON COMPLETION OF POSTING

1. As is evident from the log book, an assessment will be made qualitatively and quantitatively in the gain in skills and knowledge during the stay in the department.
2. On completion of the posting there shall be an evaluation test in theory and practical to assess the academic status of the intern. The assessment shall be on the following:

	METGIDE IF ASSESSNEBT	WEIGHTAGE
A	Day to day working and conduct at the place of work	40%
B	The assessment to gauge the clinical application of theoretic knowledge.	30%
C	Practical assessment on the topics stressed by MCI to be covered during the internship training programme.	30%

Warning:

The Interns are advised to ensure:

1. Absence from duty for a set number of days will be considered as unsatisfactory completion of the posting and the posting to be extended of the period under dispute only after which an Internship completion certificate will be issued.
2. Absence from evaluation schedules would result in lowering of the credits acquired and penalization in the form of repeating the posting may to be considered.

Time Distribution for Internship :

Department	Duration	Remarks
Community Medicine	12 weeks	a) Postings should be in Community Health Centres (CHC)/ Rural Health Centre (RHC) with rotation of : (i) 3 weeks- General Surgery (ii) 3 weeks- General Medicine (iii) 3 weeks- Obstetrics and Gynaecology (iv) 3 weeks- Community Medicine (b) Not more than 15 interns at any given time in one centre (c) As provided in the Minimum Requirements for Annual MBBS Admissions Regulations (2020) section A.1.14 related to Community Medicine must be followed.
General Medicine	6 weeks	Includes postings in out- patient, in-patient wards and admission day emergency and exposure to High Dependency Units (HDU) and Intensive Care Units (ICU)
Psychiatry	2 weeks	Predominantly Out-patient postings with exposure to handling emergencies
Paediatrics	3 weeks	Includes postings in Out- patient, In-patient wards and Admission Day Emergency postings and exposure to Neonatal or Pediatric High Dependency and Intensive Care Units (HDU/NICU/PICU)
General Surgery	6 weeks	Includes postings in Out- patient, In-patient wards, Admission Day Emergency and both Minor and Major Operation Theatres and exposure to High Dependency Units (HDUs) and Intensive Care Units (ICUs)

Anaesthesiology and Critical Care	2 weeks	Includes postings in Operation Theatre, Intensive Care Units, Basic Life Support (BSL) training and additionally Pain Clinic and Palliative Care, if available
Obstetrics and Gynaecology including Family Welfare and Planning	7 weeks	Includes postings in Out- patient, In-patient wards, Admission Day Emergency, Labour Room and Operation Theatres and exposure to High Dependency Units (HDU), Intensive Care Units (ICU)and Family Planning methods
Orthopaedics including Physical Medicine and Rehabilitation (PM&R)	2 weeks	Includes postings in Out- patient, In-patient, Admission Day Emergency, Plaster Room and Operation Theatres Postings in Physical Medicine and Rehabilitation (PM&R) may run concurrent in afternoons/mornings equivalent to 4 half-days (14% of total postings)
Emergency/ Trauma/ Casualty	2 weeks	Includes postings related to Resuscitation areas, Triage, In-patient wards and Operation Theatre, Basic Life Support as well as exposure to medico-legal procedures
Forensic Medicine and Toxicology	1 week	Includes Autopsy postings
Dermatology, Venereology and Leprology	1 week	Predominantly Out-patient postings with exposure to handling emergencies
Otorhinolaryngology	2 weeks	Predominantly Out-patient postings with exposure to handling emergencies, Minor as well as Major Operation Theatres
Ophthalmology	2 weeks	Predominantly Out-patient postings with exposure to handling emergencies, Minor as well as Major Operation Theatres
Electives Exclusive* Broad Specialties Group	4 weeks total; 2 weeks minimum,	• Respiratory Medicine and Directly Observed Treatment Short Course in Tuberculosis (DOTS-TB) Center • Radio diagnosis • Lab Medicine • Geriatric Medicine
Electives Exclusive* Indian Systems of Medicine	1 week	***May** choose any:* • Ayurveda • Yoga • Unani • Siddha • Homeopathy • Sowa Rigpa

Minimum Requirements in Clinical Skill and Patient Care in Surgery and allied, Obstetrics & Gynecology, Pediatrics, Medicine and allied & Community Medicine

The Intern shall:

1. Take a full history, carry out a complete physical examination and reach differential diagnosis and working diagnosis.
2. Order appropriate and relevant investigations and show competence in their interpretation be able to formulate a definitive diagnosis.
   i. Total blood counts(TBC)
   ii. Urinalysis
   iii. Stool
   iv. Blood sugar
   v. Urea electrolytes and creatinine (UEC)
   vi. Pus swab for culture and sensitivity including blood culture
   vii. Coagulation screen
   viii. Chest radiograph
   ix. Plain abdominal radiograph
   x. Skull radiograph
   xi. Pelvic radiograph
   xii. Lowe and upper limb radiograph
   xiii. Abdominal ultra sound
   xiv. Spine radiograph
   xv. Cervical spine radiograph 10 | Medical Internship Guidelines-2014
3. Show adequate knowledge in the management of commonly encountered conditions as per National Guidelines, best practices and shall consult and refer as necessary.
4. Be conversant with the national essential Drugs List and Dangerous Drugs Act.
5. Be proficient in recording and regular updating of patient's notes and be able to write accurate and informative case summaries.
6. Present cases concisely, coherently and competently during ward rounds, grand rounds or any other appropriate forum.
7. Observe and uphold professional ethics and etiquette in interacting with colleagues, patients and the public.
8. Demonstrate basic leadership and administrative skills.
9. Practice continuing self-learning skills and acquire basic research principles.
10. Participate in continuous Professional Development (CPD) activities.

GENERAL SURGERY

The intern shall be able to:-

1. Take a full history, carry out complete physical examination and arrive at possible different diagnosis.
2. Understand indication and contra-indications for surgery.
3. Properly document all procedures, peri-operative findings and follow-up notes.
4. Understand and participate in preoperative, intra operative and postoperative care or patients.
5. Understand, prevent and manage complications arising from surgery.
6. Understand and participate infection prevention and control principles.
7. Use antibiotics and other drugs rationally.
8. Obtain informed consent for various procedures.

9. Recognize and institute the initial Management of common emergencies such as:-
    i. Patient with multiple injuries.
    ii. Unconscious patient
    iii. Head spinal injury
    iv. Acute abdomen (gastro-intestinal bleeding, intestinal obstruction, complicated hernia, appendicitis, peritonitis and abdominal trauma)
    v. Burns
    vi. Fractures (open fractures, fracture-dislocations)
    vii. Epistaxis
    viii. Genitourinary emergencies (Urinary retention, torsion of the testis, orchitis)
    ix. Chest injuries (Pneumothorax, hemothorax, tension hemothorax)
    x. Foreign body in airway or oesophagus
    xi. Penetrating injuries(gunshots, stab wounds etc)

10. Demonstrate acquired skills as follows:-
    a) Show proficiency in the following skill:-
    i. Resuscitation and life support,
    ii. Various methods of peripheral intravenous access at different sites.
    iii. Various methods of intravenous access (cut down, long line, central line)
    iv. Intraosseous access
    v. Insertion of chest tube.
    vi. Tracheostomy
    vii. Taking lymph node and skin biopsies
    viii. Excision biopsy of common benign tumors(ganglion, lipoma, dermoid cyst)
    ix. Suturing of cuts and clean wounds
    x. Performing surgical toilet
    xi. Appropriate use of sutures and suture techniques
    xii. Incision and drainage of abscesses

xiii. Manipulation and splinting of common fractures
xiv. Collection of specimens (stool, urine, blood, peritoneal fluid, cerebrospinal fluid)
xv. Passage of nasogastric tube
xvi. Proctoscopy
xvii. Urethral catheterization
xviii. Suprapubic catheterization
xix. Abdominal paracentesis and pleural tap
xx. Interpretation of laboratory data, imaging and histology reports
xxi. Aseptic technique and theatre practice (scrubbing, gloving, gowning, patient preparation)
xxii. Counseling for presenting conditions.

b) Perform and interpret the following laboratory procedures

i. Blood sugar
ii. HIV rapid test
iii. Bed side coagulation tests
iv. Urinalysis
v. Rapid tests for Malaria Parasites
vi. Zeil Neilsen (ZN) stain for TB

c) Observe, assist and perform the following operations under supervision:

i. Herniorrhaphy (Inguinal and umbilical)
ii. Appendicectomy
iii. Exploratory Laparotomy for abdominal emergencies
iv. Thoracic catheter insertion
v. Intramedullary nail insertion and external fixation for fractures.

d) Shall have assisted common operations with an emphasis on:-

i. Resection module and anastomosis of the bowel
ii. Craniotomy burr holes for intra cranial haematomas
iii. Amputations
iv. Prostatectomy

OBSTETRICS AND GYNAECOLOGY

The intern shall be able to :

1. Take a full history, carry out complete physical examination and arrive at possible differential diagnoses and a working diagnosis
2. Properly document all procedures, peri-operative findings and follow-up notes
3. Understand indications and contra-indications for surgery
4. Understand and participate in preoperative, intraoperative and postoperative care of patients
5. Understand prevent and manage complications arising in surgery
6. Understand and practice infection prevention and control principles
7. Use antibiotics and drugs rationally
8. Obtain informed consent for carious procedures.

9. **Show proficiency in consent for carious proceduresd :**
   a) Normal pregnancy, delivery and postpartum period,
   b) Abnormal pregnancy: pre-intra and post-partum.

   c) Common emergencies in obstetrics such as :
      i. Ruptured uterus
      ii. Severe pre-eclampsia and eclampsia
      iii. Post-partum hemorrhage
      iv. Ante partum hemorrhage
      v. Puerperal sepsis
      vi. Anaemia
      vii. Abruption placenta
      viii. Placenta praevia
      ix. Puerperal psychosis12 | Medial Internship guidelines_- 20....

   d) Common gynecological emergencies such as
      i. Ectopic pregnancy
      ii. Inevitable, Incomplete and septic abortion
      iii. Pelvic abscess
      iv. Bartholin's abscess
      v. Haematocolpos and haematometra
      vi. Torsion of the ovary
      vii. Foreign bodies insertion.

   e) Common obstetrics and gynecological conditions including :
      i. Cancers of the reproductive tract
      ii. Infertility
      iii. Fibroids/ovarian cysts
      iv. Menopause

v. Abnormal uterine bleeding
vi. Menstrual disorders
vii. Sexual dysfunction

f) Principles of contraception
g) Prevention of Mother To Child Transmission

10. Demonstrate acquisition of skills.

Show proficiency in the carrying out the following :

i. Ante natal care
ii. Vaginal examination
iii. Breast examination
iv. Episiotomy
v. Normal delivery
vi. Post natal care
vii. Manual removal of placenta
viii. Repair of episiotomy and vaginal tears
ix. Vacuum aspiration of uterus (Manual and electrical)
x. Resuscitation of the newborn
xi. Drainage of pelvic absess
xii. Management of malpositions and malpresentation
xiii. Vacuum extraction
xiv. Identification and management of penetrating injuries (e.g uterine and gut perforations)
xv. Identification and management of sexual assault and rape sodomy
xvi. Counseling for presenting conditions

11. Shall observe, assist under supervision the following operations :

Caeserian section module, Repair of ruptured uterus, subtotal hysterectomy for ruptured uterus, Laparotomy for ectopic pregnancy, pelvic abscess

12. Shall assist at common operations in particular :

Repair of third degree tear, Total Hysterectomy, Salpingoplasty, Vesico Varginal Fistula repair, Laparoscopy, Laparotomy

13. Screening for common reproductive tract cancers
(Breast, cervical and prostrate cancers)

PAEDIATRICS

Daily activity

Ward activity	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
1. Case sheet written							
2. Case presentation in round							
3. Follow up documentation							
4. Discharge preparation							
5. Counseling							
Name of procedure							
6. Lumbar puncture							
7. Aspiration of pleural fluid							
8. Aspiration of bone marrow							
9. Throat swab collection							
10. Blood sample collection							
11. N-G-T insertion& feeding							
12. ORS preparation							
13. Intravenous fluid/drug							
14. Per rectal drug							
15. Intradermal drug/ test							
16. Transfusion of blood							
17. O_2 administration							
18. Inhaler and Nebulisation							
19. Abdominal paracentesis							
20. Stomach wash							
21. RBS estimation by Glucometer							
22. Slide (Film) preparation							
23. Photo therapy							
24. Open care system operation (5-2-20)							
Case Management							
25. Febrile seizure(5-5-10)							
26. Diarrhoea with dehydration(5-5-30)							
27. Pneumonia & Resp. distress(5-5-10)							
28. Severe acute Malnutrition(3-2-5)							
29. Neonatal jaundice							
30. Neonatal resuscitation							
31. LBW neonate							
32. Neonatal hypothermia							
33. Meningitis/ encephalitis							
34. Bronchial asthma							

Academic Activity							
35. Case presentation(4)							
36. Seminars(2)							
37. Group Discussion(2)							
SIGNATURE OF FACULTY							

NB : Indicate activity using O – Observed, A – Assisted and P – Performed.

Ward activity	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15
1. Case sheet written								
2. Case presentation in round								
3. Follow up documentation								
4. Discharge preparation								
5. Counselling								
Name of procedure								
6. Lumbar puncture								
7. Aspiration of pleural fluid								
8. Aspiration of bone marrow								
9. Throat swab collection								
10. Blood sample collection								
11. N-G-T insertion& feeding								
12. ORS preparation								
13. Intravenous fluid/drug								
14. Per rectal drug								
15. Intradermal drug/ test								
16. Transfusion of blood								
17. O_2 administration								
18. Inhaler and Nebulisation								
19. Abdominal paracentesis								
20. Stomach wash								
21. RBS estimation by Glucometer								
22. Slide (Film) preparation								
23. Photo therapy								
24. Open care system operation (5-2-20)								
Case Management								
25. Febrile seizure(5-5-10)								
26. Diarrhoea with dehydration(5-5-30)								
27. Pneumonia & Resp. distress(5-5-10)								
28. Severe acute Malnutrition(3-2-5)								
29. Neonatal jaundice								
30. Neonatal resuscitation								
31. LBW neonate								
32. Neonatal hypothermia								

33. Meningitis/ encephalitis								
34. Bronchial asthma								
Academic Activity								
35. Case presentation(4)								
36. Seminars(2)								
37. Group Discussion(2)								
SIGNATURE OF FACULTY								

NB : Indicate activity using O – Observed, A – Assisted and P – Performed.

Ward activity	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21	Day 22	Day 23
1. Case sheet written								
2. Case presentation in round								
3. Follow up documentation								
4. Discharge preparation								
5. Counselling								
Name of procedure								
6. Lumbar puncture								
7. Aspiration of pleural fluid								
8. Aspiration of bone marrow								
9. Throat swab collection								
10. Blood sample collection								
11. N-G-T insertion& feeding								
12. ORS preparation								
13. Intravenous fluid/drug								
14. Per rectal drug								
15. Intradermal drug/ test								
16. Transfusion of blood								
17. O_2 administration								
18. Inhaler and Nebulisation								
19. Abdominal paracentesis								
20. Stomach wash								
21. RBS estimation by Glucometer								
22. Slide (Film) preparation								
23. Photo therapy								
24. Open care system operation								
Case Management								
25. Febrile seizure								
26. Diarrhoea with dehydration								
27. Pneumonia & Resp. distress								
28. Severe acute Malnutrition								
29. Neonatal jaundice								

30. Neonatal resuscitation								
31. LBW neonate								
32. Neonatal hypothermia								
33. Meningitis/ encephalitis								
34. Bronchial asthma								
Academic Activity								
35. Case presentation								
36. Seminars								
37. Group Discussion								
SIGNATURE OF FACULTY								

NB : Indicate activity using O – Observed, A – Assisted and P – Performed.

Ward activity	Day 24	Day 25	Day 26	Day 27	Day 28	Day 29	Day 30	Day 31
1. Case sheet written								
2. Case presentation in round								
3. Follow up documentation								
4. Discharge preparation								
5. Counseling								
Name of procedure								
6. Lumbar puncture								
7. Aspiration of pleural fluid								
8. Aspiration of bone marrow								
9. Throat swab collection								
10. Blood sample collection								
11. N-G-T insertion& feeding								
12. ORS preparation								
13. Intravenous fluid/drug								
14. Per rectal drug								
15. Intradermal drug/ test								
16. Transfusion of blood								
17. O_2 administration								
18. Inhaler and Nebulisation								
19. Abdominal paracentesis								
20. Stomach wash								
21. RBS estimation by Glucometer								
22. Slide (Film) preparation								
23. Photo therapy								
24. Open care system operation								
Case Management								
25. Febrile seizure								

26. Diarrhoea with dehydration								
27. Pneumonia & Resp. distress								
28. Severe acute Malnutrition								
29. Neonatal jaundice								
30. Neonatal resuscitation								
31. LBW neonate								
32. Neonatal hypothermia								
33. Meningitis/ encephalitis								
34. Bronchial asthma								
Academic Activity								
35. Case presentation								
36. Seminars								
37. Group Discussion								
SIGNATURE OF FACULTY								

NB : Indicate activity using O – Observed, A – Assisted and P – Performed.

Assessment and scoring (recommended number)

Ward activity	Number			Score(1-5)	Sig. of faculty
38. Case sheet written(60)					
39. Case presentation in round(15)					
40. Follow up documentation(200)					
41. Discharge preparation(100)					
42. Counselling(50)					
Name of procedure	**Observed**	**Assisted**	**Performed**	**Score(1-5)**	**Sig. of faculty**
43. Lumbar puncture (3-2-)					
44. Aspiration of pleural fluid (3-2-1)					
45. Aspiration of bone marrow (3-2-1)					
46. Throat swab collection (5-3-2)					
47. Blood sample collection (15-15-15)					
48. N-G-T insertion& feeding(15-15-15)					
49. ORS preparation(5-510)					
50. Intravenous fluid/drug(5-5-30)					
51. Per rectal drug(2-2-10)					
52. Intradermal drug/ test(5-5-5)					
53. Transfusion of blood (2-2-10)					
54. O_2 administration (5-5-10)					
55. Inhaler and Nebulisation (2-2-30)					
56. Abdominal paracentesis (5-3-2)					
57. Stomach wash (2-3-5)					
58. RBS estimation by Glucometer(2-2-10)					

59. Slide (Film) preparation (2-2-10)					
60. Photo therapy (2-2-20)					
61. Open care system operation (5-2-20)					
Case Management	**Observed**	**Assisted**	**Performed**	**Score(1-5)**	**Sig. of faculty**
62. Febrile seizure(5-5-10)					
63. Diarrhoea with dehydration(5-5-30)					
64. Pneumonia & Resp. distress(5-5-10)					
65. Severe acute Malnutrition(3-2-5)					
66. Neonatal jaundice					
67. Neonatal resuscitation					
68. LBW neonate					
69. Neonatal hypothermia					
70. Meningitis/ encephalitis					
71. Bronchial asthma					
Academic Activity	**Number**			**Score(1-5)**	**Sig. of faculty**
72. Case presentation(4)					
73. Seminars(2)					
74. Group Discussion(2)					
Behavioral Attributes				**Score(1-5)**	**Sig. of faculty**
38.Punctuality					
39.Responsibility					
40.Team work capacity					

CERTIFICATE OF COMPLETION AND ASSESSMENT

Certified that Ms/Mr .....

Worked in the Department of Paediatric Medicine from ..... to .....

an satisfactorily completed the internship posting.

The intern has been assessed as follows :

Attribute	Score
1. Ward activity skill	
2. Procedure skills	
3. Case Management skill	
4. Academic Activity	
5. Behavioural Attributes	
TOTAL SCORE	
Scoring system: < 50=Below average, 50 - 100=Average, >100 - 150=Good, >150 - 175 =Very good, >175 - 200=Excellent.	**ASSESMENT**
A score ≤ 100 for any attribute may warrant repetition/extension of posting per the discretion of the Unit Head and/ or HOD	
Casual Leave	days
Absent	days
In case of extension/ Repetition The Intern was given ..... days of extension from ..... to ..... which he/she completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

GENERAL MEDICINE

This rotation will cover adolescents, adults and geriatrics.

1. Triage
2. Clerk patients : take a full history, carry out a complete physical examination, formulate provisional and differential diagnoses
3. Institute appropriate management and subsequent care in consultant with the supervisor and appropriate hand over.
   a. Be able to obtain informed consent form the patient / guardian for test and procedures
   b. Be able to request for appropriate diagnostic test including HIV testing
   c. Counsel the patient and care giver appropriately
   d. Hand over appropriately :
      i. Present the patient to the next clinician physically
      ii. Brief the incoming clinician on the management of the patient os far and document the same in the patient's notes.
4. **Manage acute medical emergencies such as** : Meningitis, convulsions, acute cerebrovascular accident, coma and cerebral malaria; severe congestive cardiac failure (CCF), myocardial infarction, hypertensive encephalopathy, pulmonary oedema, pulmonary embolism, shock, acute asthma and respiratory failure, pcp, adult respiratory distress syndrome (ards); diabetic emergencies and hypoglycaemia, gastrointestinal bleed, diarrhoea, vomiting, septicaemia, poisoning (e.g acute paracetamol, organophosphates, ethanol, methanol), acute kidney injury and acute liver failure, tetanus, anaphylactic reactions and substance abuse.
5. Shall manage common medical conditions in accordance with current standard clinical guidelines in including but not limited to the following :15 | Medical Internship guidelines -2014 malaria, anemia, pneumonia, tuberculosis, tetanus, sexually transmitted diseases and HIV/ AIDS, hypertension, cardiovascular accident (CVA) Heart failure, rheumatic heart disease, infectious endocarditic, myocardial infarction, hepatitis, liver cirrhosis, chronic liver disease, hematoma, pulmonary, oedema and bronchial asthma, renal failure, skin disorders. Endocrine disorders including thyroid diseases, oncological conditions.
6. Shall manage chronic medical conditions in accordance to current standard clinical guidelines. These conditions include- diabetes, hypertension, dyslipidemia, chronic obstructive lung diseases, HIV, tuberculosis; dermatological condition, obesity and life style interventions shall be part of management of these conditions.
7. Participate in preventive and promotive health activities.
8. Shall be able to identify and manage in consultation with the supervisors psychiatric emergencies and conditions such as suicidal tendencies ; substance abuse, depression, stress, anxiety, mood affective disorders
9. Skills

   a) Show proficiency in carrying out the following : -

      i. Triage

ii. Cardio-pulmonary resuscitation, intubation and vascular access
iii. Venepuncture and withdraw appropriate samples for investigations,
iv. I-V fluids and bloods transfusion,
v. Nasogastric tube insertion and gastric lavage,
vi. Lumbar puncture
vii. Pleural, peritoneal and joint aspiration
viii. Bone marrow and fine needle aspiration,
ix. Biopsy of lymph nodes and skin;
x. Proctoscopy, sigmoidoscopy and rectal snip
xi. Examine and interpret stool, urine, CSF and sputum results
xii. Estimate levels of hemoglobin, glucose and bilirubin in blook
xiii. Prepare blood slide and examine for malaria parasites.
xiv. Interpret routine radiographs of the chest, skull, abdomen, and the extremities with respect to trauma, infection and neoplasia.
xv. Basic interpretation of special examinations of the alimentary, cardiovascular, central nervous, respiratory and genitor-urinary systems, ECG, pericardial effusion.

10. Shall have observed, assisted and preferably performed under supervision the following :
    i. Exchange transfusion
    ii. Chest tube insertion
11. Shall have observed the following:
    i. Liver biopsy
    ii. Renal biopsy
    iii. Splenic aspirate
    iv. Post mortem examination
12. Demonstrate appropriate communication and counseling skills
13. Demonstrate ethical behavior in line with the professional code of conduct and ethics.
14. Participate in continuous professional development activities.16 | Medical Internship Guidelines-2014
    i. organize orientation of interns
    ii. organize monthly meetings
    iii. ensure interns are given timely feedback on performance and assured of confidentiality
    iv. ensure interns give feedback to the hospital
    v. ensure Internship forms

ORTHOPAEDICS

(A) THERAPEUTIC

An intern must know:

(a) Splinting (plaster slab) for the purpose of emergency splintage, definitive splintage and post operative splintage and application of Thomas splint;
(b) Manual reduction of common fractures – phalangeal, metacarpal, metatarsal and colles's fracture;
(c) Manual reduction of common dislocations-internphalangeal,
(d) Plaster cast application for undisplaced fracture of arm, fore arm, leg and ankle'
(e) Emergency care of a multiple injury patient;
(f) Precautions about transport and bed care of spinal cord injury patients.

(B) Skill that in intern should be able to perform under supervision:

(1) Advise about prognosis of poliomyelitis, cerebral palsy, CTEV and CDH
(2) Advise about rehabilitation of mutilating traumatic and leprosy deformities of hand.

(C) An intern must have observed or preferably assisted at the following operations:

(1) Drainage for acute osteomyelitis;
(2) Sequestrectomy in chronic osteomyelitis;
(3) Application of external fixation;
(4) Internal fixation of fractures of long bones.

CASUALTY & TRAUMA

The intern after training in casualty must be able to:

(1) Identify acute emergencies in various disciplines of medical practice.
(2) Identify acute emergencies in various disciplines of medical practice.
(3) Manage acute anaphylactic shock.
(4) Manage peripheral-vascular failure and shock.
(5) Manage acute pulmonary oedema and Left Ventricular failure (LVF)
(6) Undertake emergency management of drowning poisonings and seizures;
(7) Undertake emergency management of bronchial asthma and status asthematicus;
(8) Undertake emergency management of hyperpyrexia;
(9) Undertake emergency management of comatose patients regarding girways positioning prevention of aspiration and injures;
(10) Assess and administer emergency management of burns;
(11) Assess and do emergency management of various trauma vitcitm;
(12) Identify medicolegal cases and learn filling up forms as well as complete other medicolegal formalities in cases injury, poisoning, sexual offenses, intoxication and other unnatural conditions.

ANAESTHESIOLOGY

(1) Perform pre-anaesthetic check up and prescribe pre-anaesthetic medications;
(2) Perform venepuncture set up intravenous drip;
(3) Perform laryngoscope and endotracheal intubation;
(4) Perform lumbar puncture, spinal anesthesia and simple nerve blocks;
(5) Conduct simple general as aesthetic procedures under supervision
(6) Monitor patients during anesthesia and post operative period;
(7) Recognize and manage problems associated with emergency anesthesia;
(8) Maintainanaesthetic records;
(9) Recognize and treat complication in post operative period;
(13) Perform cardio-pulmonary brain resuscitation (C.P.B.R) correctly, including recognition of cardiac arrest.

COMMUNITY MEDICINE

The interns should compulsorily attend training in each of the following skills in the Department of Community Medicine as furnished below;
Interns shall acquire skills to deal effectively with an individual and the community in the context of primary health care. This is to be achieved by hands on experience in the district Hospital and primary health Center.

<u>The details are as under:-</u>

(I) COMMUNITY HEALTH CENTRE
(Rural health centre, AGMC & GPB hospital /Urban health centre):
(1) During this period of internship an intern must acquire.
(a) Clinical competence for diagnosis of common ailments prevailing in the community of the area, use of bed side investigation and primary care techniques;
(b) Fain information on 'Essential drugs' and their usage;
(c) Recognize medical emergencies, resuscitate and institute initial treatment and refer to suitable institution.

(2) Undergo specific government of India/Ministry of Health and family Welfare approved training using Government of India prescribed training manual for medical Officers in all National Health Programmes (e.g. child survival and safe motherhood- EPI, CDD,ARI, FP, ANC, safe delivery, Tuberculosis, Leprosy and other as recommended by Ministry of Health and Family Welfare/ Tripura state Health society Manual:-
(a) Gain full expertise in immunization against infectious disease;
(b) Participate in programmes in prevention and control of locally prevalent endemic diseases including nutritional disorders;
(c) Learn skills first hand in family welfare planning procedures;

(d) Learn the management of National Health Programmes;

(3) Be capable of conducting a survey and employ its findings as a measure towards arriving a community diagnosis.
   (a) Conduct programmes on health education,
   (b) Gain capabilities to use Audiovisual aids,
   (c) Acquire capability of utilization of scientific information for promotion of community health and basic skill in bio-statistics

(4) Be capable of establishing linkages with other agencies as water supply, food distribution and other environmental/social agencies.

(5) Acquire quality of being professional with dedication, resourcefulness and leadership.

(6) Acquire managerial skills, delegation of duties to paramedical staff and other health professionals.

(7) Make a community diagnosis in specific situations as epidemics and Out-breaks;

(8) Develop capability for analysis of hospital based morbidity and mortality statistics. Besides national programme on :
   (a) Tuberculosis
   (b) Small family, spacing, use of appropriate contraceptives;
   (c) Applied nutrition and care of mother and children;
   (d) Immunization;
   (e) Participation in school health programme.
   (f) Kalazar, J.E, A.E.S., Dengue, Malaria, HIV etc.

Title of Research Project submitted

Remarks **Signature of In-Charge** **Signature of HOD**

DEPARTMENT OF COMMUNITY MEDICINE

Two(2) months posting w.e.f. …… to …… date : ……

Serial No.	SKILL/ACTIVITY	PHC/CHC (1 Month)		UTCH – 15 days	Department 15 days from …… to ……
		RHTC-CHC From …… To ……	PHC From …… To ……		
		No. of cases	No. of cases	No. of cases	
1.	**Medical care (OPD/Indoor)**				
1.1	Patient Examined				
1.2	Emergencies attended				
1.3	Dressing				
1.4	I/M Injection				
1.5	I/V Injection/ Drip				
1.6	Wound stitched				
1.7	Abscesses Drained				
1.8	Medico legal cases Observed				
1.9	Post Mortem Observed				
1.10	Others				
2.	**Family planning and MCH Service**				

2.1	Antenatal Check-ups				
2.2	Deliveries Conducted				
2.3	Episiotomies				
2.4	BCG/Polio/DPT/ Measles				
2.5	Tetanus/Toxoid				
2.6	Family clinic attended				
2.7	IUD Insertion				
2.8	Tubectomy attended				
2.9	Vasectomy attended				
3	**Lab. Investigation**				
3.1	Urine Examination				
3.2	Stool Examination				
3.3	Blood Examination				
3.4	AFB Examination				
3.5	Others				
4	**Field Activities**				
4.1	School Health Check-up				
4.2	IEC/Health Talk				
4.3	Sub Centre Visit				
4.4	Monthly Meeting Attended				
4.5	Outbreak control measures				

5	**Managerial skills**				
5.1	Exercise				
5.2	Role play				
5.3	Spot/simulation exercise				
5.4	Analysis of records				
6	**Miscellaneous**				
6.1	Journal club/ seminars				
6.2	Charts prepared				
6.3	Others				

Activities performed by the intern to be recorded below		Signature of staff with date
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CERTIFICATE OF COMPLETION AND ASSESSMENT

DEPARTMENT OF COMMUNITY MEDICINE

Certified that Dr. .....

Worked in the Community Medicine Department from ..... to .....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavioral Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

GENERAL MEDICINE

Period of posting: From ..... to ..... .

Duration of posting : 2 Months (Including 15 days of Psychiatry)

Date of Reporting

Signature of staff

WORK DONE STATEMENT

Sl. No.	Activity with numbers Recommended	Numbers Performed Assisted and Observed as the case may be	Date and signature of staff
1.	OPD Cases to be seen(50)		
2.	Case sheets to be written(50)		
3.	Number of follow ups to be written(100)		
4.	Number of discharge summaries to be written(50)		
5.	Monitoring of critically ill patients(20)		
6.	Basic lab investigations to be done(20) HB, TC, DC, ESR, Urine Exam etc.		
7.	Blood samples to be drawn(10)		
8.	Injections to Be given (10) I.V I.M S.C		
9.	I.V. Cannulas to be inserted (10)		
10.	Ryle's to be inserted(2)		
11.	Catheterization to be done(2)		
12.	Pleural / Ascitic fluid aspirations to be done(2)		
13.	Bone marrow aspirations/ CSF tap(any 2) to be done		

14.	Nebulizations to be given(10)		
15.	Oxygen Delivery(10)		
16.	Cardiac monitoring to be observed(5)		
17.	Assisted in CRP(2) Intubation(2) Defibrillation(2)		
18.	Resuscitation of patients in shock(2)		
19.	Revealing bad news to relatives(4)		
20.	Recording of ECGs to be done(20)		
21.	Emergencies to be attended to (20)		
22.	Blood transfusions to be given and monitored(10)		
23.	Bone Marrow Aspiration and liver Biopsy to be programmed(2)		
24.	Attendance and participating in Health education Programmes(2)		

Please note that the numbers in brackets are as per recommendations by the medicine department

General Instructions :

1) Out of 2 months posting in the medicine department, one week shall be spent in I.C.U
2) Interns must report for duty at 8:00 am. Daily and continue till evening rounds, with lunch and breaks in between. During 24 hours ward duty the intern will be first on call for all in patients and therefore, he will residing in the hospital on those days.
3) The Log Book will be filled up daily and signature of authorized person obtained.
4) Sending samples for laboratory investigations and subsequently getting the report will be the & responsibility of the Intern
5) Certification of the Log Book should be done on the last of the posting.

CERTIFICATE OF COMPLETION AND ASSESSMENT

DEPARTMENT OF GENERAL MEDICINE

Certified that Dr. .....

Worked in the General Medicine Department from ..... to .....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavioural Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

PSYCHIATRY

Period of postings: From.....to.....

Duration of Posting : 15 days

Date of Reporting :

Signature of staff

WORK DONE STATEMENT

Activity	Date and Signature of staff
1. Diagnosis and management of common psychiatric disorder	
2. Identify and manage psychological reaction and psychiatric disorders in medical and surgical patients	
3. Psychological counseling skills psychotherapy.	
4. Managing psychiatric emergencies	
5. Enhancement of academic knowledge through participation in case conferences, seminar, deptt. Academic calendar	

Activities performed by the Intern to be recorded below		Signature of staff with date
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CERTIFICATE OF COMPLETION AND ASSESSMENT

DEPARTMENT OF PSYCHIATRY

Certified that Dr. .....

Worked in the Psychiatry Department from.....to.....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavioural Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

CASULTY UNIT

Period of posting : From ..... to .....

Duration of posting: 15 days
Date of Reporting :

Signature of staff

WORK DONE STATEMENT

Activity with numbers Recommended	Date and Signature of staff
1. Identify acute emergencies in various disciplines(1)	
2. Manage acute anaphylactic shock (1)	
3. Manage peripheral vascular failure and shock(1)	
4. Manage acute pulmonary oedema and left ventricular failure(1)	
5. Undertake emergences management of drawing poisoning and seizures(1)	
6. Undertake emergences management of bronchial asthma and status asthmaticus(1)	
7. Undertake emergency management of comatose patient(1)	
8. Undertake emergency management of comatose patient(1)	
9. Assess and administer emergency management of burns(1)	
10. Assess and manage trauma victim(1)	
11. Identify medico-legal cases and learn filling up forms as well as complete other medico-legal formalities in cases of injury, poisoning, sexual offences, intoxication and other unnatural conditions (1)	

Activities performed by the Intern to be recorded below		Signature of staff with date
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CERTIFICATE OF COMPLETION AND ASSESSMENT

DEPARTMENT OF CASUALTY

Certified that Dr. .....

Worked in the Casualty Department from ..... to .....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavioural Attitude	
6. Communication Skill	

Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent

A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD

Casual Leave	days
Absence	days

In case of extension / repetition

The Intern was given ..... days of extension from ..... to .....

which He / She completed satisfactorily on .....

Signature of Unit Head
with date

Signature of HOD
with date and seal

GENERAL SURGERY

Period of posting : From ..... to .....

Duration of Posting 15 days

Date of reporting : .....

Signature of staff

WORK DONE STATEMENT

Level* Performed Assisted Observed	Note: Interns should fill up the details f the procedure and get it signed By the unit Resident immediately. The endorsement should be Countersigned by the MOIC before leaving the unit

No	Activity with numbers Recommended	Level	Date	Patient Name	CR/ UHID No.	Remarks	Signature of SR/ Faculty With date
1	Resuscitation of a critically injured patient and a serve burns patient(1)						
2	Control surface bleeding and manage open wound(1)						

3	Monitor patients of head, spine, chest, abdominal and pelvic injury (1)						
4	Institute first line management of acute abdomen(1)						

5.	Perform venesection (1)						
6	Perform tracheostomy and endotrachacheal intubation						
7	Catheterize patients with acute retention(1)						

8.	Drain superficial abscess(1)						
9.	Suture wound(1)						
10.	Perform circumcision(1)						

12.	Perform Vasectomy(1)						

Apart from all of the above, an Intern, is expected to acquire skills with reasonable accuracy to diagnose and manage commonly encountered surgical illnesses and emergencies.

CERTIFICATE OF COMPLETION AND ASSESSMENT
DEPARTMENT OF GENERAL SURGERY

Certified that Dr. .....

Worked in the General Surgery Department from ..... to .....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavioral Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

ANAESTHESIOLOGY

Period of posting : From ..... to .....

Duration of posting : 15 days
Date of Reporting :

Signature of staff

WORK DONE STATEMENT

Sl. No	Activity with Numbers Recommended	Date and signature of staff
1.	Pre-anaesthetic check-up of all allotted patients	
2.	Vanepuncture I.V. Drip of all allotted patients	
3.	Laryngoscopy and endotracheal intugation (5,5,5)	
4.	C.P.R. on mannequins and also on patients.	
5.	Monitor patients during anaesthesia and post-operative period of all allotted patients.	
6.	Maintain anaesthetic record of all allotted patints.	
7.	L.P. and spinal anaesthesia(5,5,5)	
8.	I.C.U. Posting for 3days	

Activities performed by the intern to be recorded below		Signature of staff with date
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CERTIFICATE OF COMPLETION AND ASSESSMENT

DEPARTMENT OF ANAESTHESIOLOGY

Certified that Dr. .....

Worked in the Anaesthesiology Department from ..... to .....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavioural Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

OTORHINOLARYGOLOGY (E.N.T)

Period of posting : From.....to .....

Duration of posting: 15 days
Date of Reporting:

Signature of staff

WORK DONE STATEMENT

	Activity	Observed	Assisted	Performed	Date and signature of staff
1	Use of head mirror				
2	Use of Otoscope				
3	Use of Indirect Laryngoscope				
4	Ear syringing				
5	Antrum puncture				
6	Packing of epistaxis				
7	Packing of external auditory canal				
8	Removal of foreign body nose and ear				
9	Endoscopy procedures				
10	Tranchostomy				
11	Rehabilitative pragrammes for ENT problems				

Activities performed by the intern to be recorded below		Signature of staff with date
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CERTIFICATE OF COMPLETION AND ASSESSMENT
DEPARTMENT OF OTORHINOLARYGOLOGY (E.N.T)

Certified that Ms. / Mr. .....

Worked in the E.N.T. Department from ..... to .....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Initiative	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

OPTHAMOLOGY

Period of posting : From.....to .....

Duration of posting: 15 days
Date of Reporting:

Signature of staff

WORK DONE STATEMENT

Activity	Observed	Assisted	Performed	Date and signature of staff
1. Diagnose and management				
a)Trauma & Ocular emergencies				
b)Acute Conjunctivitis				
c)Allergic Conjunctivitis				
d) Xerosis				
e)Entropion				
f) Coprneal Ulcer				
g) Iridocyclitis				
h) Myopia				
i)Hypermetropia				
j)Cataract				
k)Glaucoma				
l)Ocular Injury				
m)Sudden loss of Vision				
I. Assessment of refractive errors				
II. Perform investigative procedure				
a) Tonometry				
b) Syringing				
c) Direct Ophthalmocsopy				
d) Fluorescence staining of cornea				

Activity	Observed	Assisted	Performed	Date and signature of staff
III. Perform / Assist the following procedure				
a) Sub conjunctival Injection				
b) Ocular Bandaging				
c) Removal of concretion				
d) Epilation and electrolysis				
e) Corneal foreign body removal				
f) Cauterization of corneal ulcer				
g) Chalazion removal				
h) Entropion correction				
i) Suturing tear of conjunctiva				
j) Lid repair				
k) Glaucoma surgery				
l) Enucleation of eyes in cadaver				

Activities performed by the intern to be recorded below		Signature of staff with date
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CERTIFICATE OF COMPLETION AND ASSESSMENT

DEPARTMENT OF OPTHAMOLOGY

Certified that Dr. . .....

Worked in the Ophthalmology Department from.....to.....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavioural Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

DEPARTMENT OF ORTHOPEDICS

Period of posting : From.....to .....
Duration of posting: 15 days
Date of Reporting:

Signature of staff

The aim of training on Orthopedics in to impart such knowledge and skill that may enable the intern to diagnose and treat conditions like fractures, dislocations, oesteomylitis, congenital deformities etc.

WORK DONE STATEMENT

Activity	Observed	Assisted	Performed	Date and signature of staff
OUT PATIENTS				
1. Examination of patients				
2. Application of plaster for undisplaced fracture of arm, forearm, leg and ankle				
3. Manual reduction of common dislocations : Iterphalangeal, Metacarpophalangeal, Elbow, shoulder				
4. Intra-articular injections				
5. Emergency care of patients with multiple injuries				
6. Transportation of a patient with spine injury				
7. Advice to patients with polio-myelitis, cerebral palsy, rehabilitation of amputees, leprosy, Deformity etc.				

WORD DONE STATEMENT

Activity	Observed	Assisted	Performed	Date and signature of staff
IN PATIENTS				
Work up of cases application and maintenance of traction				
OPERATION THEATRE				
1. Reduction of colles's fracture				
2. Reduction of anterior dislocation of shoulder and elbow				
3. Management of greenstick fractures				
4. Skin closure				
5. Drainage for acute osteomyelitis				
6. Sequesterectomy				
7. Internal and external fixation				

CERTIFICATE OF COMPLETION AND ASSESSMENT

DEPARTMENT OF ORTHOPEDICS

Certified that Dr. .....

Worked in the Orthopedics Department from..... to .....

an satisfactorily completed the internship posting. The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Initiative	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION (PMR)

Certified that Dr. .....

Period of posting : From.....to .....

Date of Reporting:

Signature of staff

Interns are expected to acquire the following skills :

1. Competence for clinical diagnosis based on detailed history and assessment of common disabling condition like poliomyelitis, cerebral palsy, hemiplegia, paraplegia, amputations etc.
2. Participation as a team member in total rehabilitation including appropriate follow up of common disabling conditions.
3. Principles and procedures of fabrication and repair of artificial limbs and appliances.
4. Various therapeutic modalities.
5. Use of self-help devices and splints and mobility aids.
6. Familiarity with accessibility problems and home making or the disable. Ability to demonstrate simple exercise therapy in common conditions like prevention deformity in polio, stump exercise in amputees etc.

Activities performed by the intern to be recorded below		Signature of staff with date
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CERTIFICATE OF COMPLETION AND ASSESSMENT

DEPARTMENT OF PMR

Certified that Dr. . .....

Worked in the PMR Department from ..... to .....

an satisfactorily completed the internship posting. The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Initiative	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

Department of Obstetrics and Gynecology including Family welfare

Two months Posting w.e.f. ..... to .....

Date of reporting : ..... Signature of staff :

WORK DONE STATEMENT

Level* Performed Assisted Observed	Note: Interns should fill up the details f the procedure and get it signed By the unit Resident immediately. The endorsement should be Countersigned by the MOIC before leaving the unit

No.		Activity with number recommended	Patient Name	Observed/ Assisted	UHID/ CR. No-	OPD/ Ward/	Grade	Signature of unit resident	Signature of Faculty
1	A	Diagnosis of early pregnancy							
	B	Antenatal care							
2		Diagnosis of pregnancy related to							
	A	Abortions							

	B	Ectopic Pregnancy							
	C	Tumours complicating Pregnancy							
	D	Acute abdomen in early Pregnancy							
	E	Hyper emesis gravidum							
3		Selection of High Risk Pregnancy cases and suitable advice							
	A	PIH							

	B	Polyhydramnios							
	C	Antepartum haemorrhage							
	D	Multiple pregnancies							
	E	Abnormal presentations							
	F	Intrauterine growth retardation							
4	A	Antenatal pelvic assessment							

	B	Detection of cephalo pelvic disproportion							
5		Induction of labour and amniotomy(under supervision)							
6	A	Management of Normal Labour							
	B	Detection of abnormalities Labour							
	C	Post partum Haemorrhage							
	D	Repair of Perineal Tear							

7		Assist in forceps delivery							
8		Assist in Caesarian section post operative care there of							
9		Detection and management of abnormalities of labour							
10		Perform nonstres test during pregnancy							

11		Perspeculum, per vaginal and per rectal examination for defecation of common congenital inflammatory Neoplastic and traumatic conditions of vulva, vagina uterus and ovaries							
12		Observe medico legal examination in obstetrics and gynecology							
13		Perform minor procedures							

	A	Dilatation & curettage and fractional curettage							
	B	Endometrial biopsy							
	C	Endometrial ablation							
	D	Pap smear collection							
	E	IUCD Insertion							
	F	Minilap Ligation							

	G	Urethral catheterization							
	H	Suture removal in post operative cases							
	I	Cervical punch biopsy							
14		To assist in major abdominal and vaginal surgery cases in obstetrics and gynecology							
15		To assist in follow up post- operative cases of obstetrics and							

		gynecology							
	A	Colposcopy							
	B	Second Trimester MTP procedures eg. Emcredyl nad instillation							
16		To evaluate and prescribe oral contraceptives							

Note: Interns should fill up the details of the procedure and get it signed by the unit Resident immediately. The endorsement should be countersigned by the faculty before leaving the unit.

Activities performed by the Intern to be recorded below		Observed / Assisted / Performed under Supervision	Signature of staff with date
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CERTIFICATE OF COMPLETION AND ASSESSMENT

Department of Obstetrics and Gynecology

Certified that Ms. / Mr. .....

Worked in the Obstetrics & Gynecology Department from ..... to .....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Initiative	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

ELECTIVES : I – DEPARTMENT OF DERMATOLOGY AND SEXUALLY TRANSMITTED DISEASES

Certified that Dr. . .....

Period of posting : From.....to .....

Duration of posting: 15 days

Date of Reporting:

Signature of staff

WORK DONE STATEMENT

Activity	Observed	Assisted	Performed	Date and Signature of staff
1. Clinical examination, diagnosis management dermatological conditions				
2. Perform simple procedures				
a) Scraping for fungus				
b) Slit smear for AFB				

Date :

Signature of HOD with Stamp

DEPARTMENT OF RADIODIAGNOSIS

Certified that Dr. . .....

Worked in the Radiodiagnosis Department from.....to.....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavior and Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

DEPARTMENT OF RADIODIAGNOSIS

Name of the Internee : .....

Period of posting : From.....to .....

Duration of posting: 1 (one) month

Date of Reporting:

Signature of staff

WORK DONE STATEMENT

Activity	Observed	Assisted	Performed	Date and signature of staff
1. Identify and diagnosis Emergency room, acute abdominal conditions & acute trauma				
2. Assist in various investigations & Clinical procedures related with conventional X-rays etc.				
3. Learn about sophisticated imaging modalities CT Scan, MRI and Sonography.				
4. Know about Mammography if available.				
5. Imaging of Obstetrics and Gynaecology. To know about PCPNDT Act.				
6. Different Orthopaedics related X-rays.				

Date :

Signature of HOD with Stamp

ELECTIVE EXCLUSIVE : Indian System of Medicine

Ayurveda

Certified that Dr. . .....

Worked in the ..... Department from.....to.....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavior and Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

ELECTIVE EXCLUSIVE : Indian System of Medicine

Ayurveda

Name of the Internee : .....

Period of posting : From.....to .....

Duration of posting : 7 days

Date of Reporting :

Signature of staff

WORK DONE STATEMENT

Sl. No.	Activity	No. of cases	Date and signature of staff
1.	Introduction and orientation to Ayurveda Fundamental principles – Dosha, Dhatu, Agni, Kostha, Prakriti etc & interaction.		
2.	Introduction to Rosapanchaka, knowledge of dosage forms, bhooma & bhasma parishka, erposure to Rashashala.		
3.	Introduction of Panchakarma (concept of sadhana, Pradhana karma, Upakarma, ritusodhana etc.) IPD round & attended OPD exposure to Panchakarma procedures.		
4.	Introduction to Prasuti, Strirog and Kaumarbhritya, IPD rounds		
5.	Introduction to shalakyatantra and kriyakalpa		
6.	Introduction to Shalyatantra, IPD rounds and attending OPD		
7.	Evaluation and attending OPD		

Signature of Unit Head
with date

Signature of HOD
with date and seal

ELECTIVE EXCLUSIVE : Indian System of Medicine
Homeopathy

Certified that Dr. . .....

Worked in the ..... Department from.....to.....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavior and Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

ELECTIVE EXCLUSIVE : Indian System of Medicine
Homeopathy

Name of the Internee : .....

Period of posting : From.....to .....

Duration of posting : 7 days

Date of Reporting :

Signature of staff

WORK DONE STATEMENT

Sl. No.	Activity	No. of cases	Date and signature of staff
1.	Indoor Work (Homoeopathic case taking, diagnosis, Management)		
2.	Outdoor work (spot diagnosis and approach to management) & Homoeopathic Drug selection		
3.	Procedures performed / assisted		
4.	Homoeopathic case REPERTORISATION		
5.	Miasmatic treatment on the base totality of symptom (as per Homoeopathic guideline)		

Signature of Unit Head
with date

Signature of HOD
with date and seal

DEPARTMENT OF RESPIRATORY MEDICINE

Certified that Dr. . .....

Worked in the Respiratory Medicine Department from.....to.....

an satisfactorily completed the internship posting.

The Intern has been assessed as follows:

Attribute	Score
1. Proficiency of knowledge	
2. Competency of skills	
3. Responsibility and punctuality	
4. Capacity to work in a team	
5. Behavior and Attitude	
6. Communication Skill	
Scoring system: 0 = Poor; 1 = fair; 2 = Below Average; 3 = Average; 4 = Above Average; 5 = Excellent	
A score of less than 3 for any attribute may warrant repetition / extension of posting per the discretion of the Unit Head and / or HOD	
Casual Leave	days
Absence	days
In case of extension / repetition The Intern was given ..... days of extension from ..... to ..... which He / She completed satisfactorily on	

Signature of Unit Head
with date

Signature of HOD
with date and seal

DEPARTMENT OF RESPIRATORY MEDICINE

Period of posting : From.....to .....

Duration of posting: 15 days

Date of Reporting:

Signature of staff

WORK DONE STATEMENT

Sl. No.	Activity	No. of cases	Date and signature of staff
1.	Indoor work(History, Clinical examination diagnosis management of common respiratory disorders & emergencies)		
2.	Outdoor work(spot diagnosis and approach to management)		
3.	Procedures performed/assisted		
3.1	Sputum collection, staining method Examination of AFB under microscope		
3.2	Interpretation of chest X-rays		
3.3	Interpretation of CECT of Thorax		
3.4	Performing & Interpretation PFT		
3.5	Pleural Aspiration		
3.6	Bronchoscopy		
3.7	Chest Tube Insertion		

Date :

Signature of HOD with Stamp

ELECTIVES : IV – DEPARTMENT OF FORENSIC MEDICINE AND TOXICOLOGY

Certified that Dr. . .....

Period of posting : From ..... to .....

Duration of posting : 15 days

Date of Reporting :

Signature of staff

Interns opting for this posting are to be posted in the Casualty Department of the ..... at the same time. The objectives are as follows

To indentify and learn medico-legal responsibilities of a medical doctor in hospital situations

To be able to diagnose and learn management of common poisoning conditions in the community

To learn to handle sexual assault cases

To learn to prepare medico-legal reports

To learn medico-legal post-mortem procedures including formalities during its performance by Police

Date : Signature of HOD with Stamp

ELECTIVES : V – BLOOD BANK

Certified that Dr. . .....

Period of posting : From ..... to .....

Duration of posting : 15 days

Date of Reporting :

Signature of staff

WORK DONE STATEMENT

SL. No.	Activity to be performed by the Intern with recommended numbers	Date and signature of staff
1.	Medical examination of Blood Donors(10)	
2.	Collection of Blood from Donors(10) Or Attendance at ONE Blood Donation Camp	
3.	Collection of sample for grouping and cross match(5)	
4.	Filling up of requisition from(5)	
5.	Observation of grouping and cross match test(5)	
6.	Observation of ELISA test, Coombs test, storage, preparation of components	
7.	Filling up of post transfusion forms in suspected transfusion Reactions(3)	
8.	Collection of post-transfusion blood and urine samples(3)	

Date :

Signature of HOD with Stamp

Activities performed by the intern to be recorded below		Signature of staff with date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

DEPARTMENTAL CLEARANCE CERTIFICATE

Name of the Internee :

Name of the Department : **Community Medicine**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **Medicine & Psychiatry**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **Surgery & Anesthesiology**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **Obstetrics & Gynecology**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Internee :

Name of the Department : **Pediatrics**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **Orthopedics & PMR**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **Eye**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **ENT**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **Radio-diagnosis**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **Respiratory Medicine**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **Ayurveda / Homeopathy**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Internee :

Name of the Department : **Casualty**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)

Name of the Department : **(Elective)**

Grade

Poor	Fair	Below	Average	Above average	Excellent
			C	**B**	**A**

Signature of HOD/ I/c HOD
(with Seal)