Eligibility/ Audit Form for Recognition
And Re-recognition Of Hospitals for RD Students
(To be filled by the hospitals by 31st of March every year)

Tick appropriately

1. Name of hospital:

☐ Government/Public sector
☐ Semi-government
☐ Private (corporate)

a. Is the hospital accredited?

   Specify the accreditation: _____________________

Address of hospital:
   Street  :
   City  :
   State  :
   Country  :
   Pin code  :
   Bed strength  :

2. Type of hospital

   Single super specialty, if yes specify ____________________________

Please tick the appropriate box for Departments available.

☐ Endocrinology
☐ Cardiac
☐ Medicine
☐ Surgery
☐ Nephrology
☐ Gastroenterology
☐ Intensive care
☐ Pediatric care
☐ Any other
3. Does the hospital have OPD facility for Dietician? □ Yes  □ No

   If yes, number of patients seen per day __________________________

4. Details of dieticians

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<tr>
<th>Designation (eg. Chief/ Senior/ Junior)</th>
<th>Name</th>
<th>No. of clinical hours per week</th>
<th>Years of experience in current hospital</th>
<th>Qualifications (RD/Non-RD)</th>
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5. Documents to be submitted:
   1. RD certificate / experience certificates of all eligible dieticians wanting to train students. Experience certificates should be signed by hospital authority.
   2. Job description of all dieticians
   3. C.V of all dieticians eligible to take RD interns.
   4. List of students trained during the last curriculum year from August (Form in Annexure 1)

1. Physical audit will be conducted for all the new hospitals to be recognized by RD Board representative.
2. All hospitals to be re-recognized need to submit this form every year before 31st March / any change in staffing.
3. However audit for any hospital can be conducted anytime with prior intimation at the discretion of the board.

Chief Dietician:  Medical Director / CEO /:
                   Hospital Authority / administrator

Signature:       Signature:
Mobile no.:      Mobile no:
Email ID:        Email ID:
FOR OFFICE USE ONLY

Approval certificate for 20____ - 20____

This is to certify that _________________________ hospital is eligible to take ________ students per year by the following trainers for 3/6 months RD internship:

1.
2.
3.
4.

________________________________________
Signature
(Chairperson, RD Board)