



INDIAN FERTILITY SOCIETY

APPLICATION FORM FOR APPROVAL OF CENTRE TO PROVIDE TRAINING FOR FELLOWSHIP IN INFERTILITY AND ART

Name of centre:

Address:

Phone number:

Email id:

Ownership:-

ICMR registration number:

PNDT registration number:

Name of the medical director responsible for training:

Qualification: Enclose detailed curriculum vitae and copies of certificates

Number of centres operated give name and details of all:

IFS membership number and date:

Facilities provided at centre/ which is to be recognized for fellowship: give details of procedures done , along with approximate number performed per year under each category.

- ☐ Ultrasound
- ☐ Embryology
- ☐ Andrology
- ☐ Endoscopy
- ☐ Obstetrics
- ☐ Others

Approximate number of OPD patients new and old

Details of ART specialist: Give detailed list along with qualification and years of experiences in ART. Enclose CV and copies of certificates.

Details of embryologists: visiting

- Resident Give detailed list along with qualifications and year of experience in ART. Enclose copies of certificates.

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Number of nursing staff involved in ART: Give detailed list along with qualifications and year of experience in ART.

Name, Email and Phone No. Of Contact person

Application fees

Date:

Signature of applicant

Place: