

**A. Course concerned proforma**  
**DEGREE IN CARDIO VASCULAR TECHNOLOGY**

**Details of infrastructure facilities available in the institute**

Sl. No.	Details	Detailed area In Sq. metre	Available No.
a.	Built in area of building proposed for the course (after excluding common area mentioned in the general proforma)		
b.	Number of Lecture hall (With its available / proposed facilities)		
c.	Number of Open Heart OT		
d.	Seminar room with facilities i) Table ii) Chair iii) Audiovisual aids - OHP iv) LCD projector v) Computer		
e.	General store with facilities		
f.	Common toilet – a) for Boys b) for Girls		
g.	Faculty rooms & staff rooms		

27. Whether the institute has a functional hospital of your own :  
 If yes, Total number of out patients/month  
 Total number of in-patients/month :
28. Whether the hospital have the facility of 24 hour casualty:  
 If yes, Total number of out patients/month :
29. Whether the hospital has a well functioning cardiology department  
 If yes, Total number of out patients/month :  
 Total number of in-patients/month :
30. Whether the hospital has a well functioning cardiothoracic Surgery department:  
 If yes, Total number of out patients/month :  
 Total number of in-patients/month :  
 Average number of cardiothoracic surgery/month :  
 Total no.of cases done for the last 2 years :
31. Total working area in the theatre for cardiothoracic surgery :
32. Total number of operation table in the theatre :

33. Whether the hospital has a well functioning intensive cardiac :  
coronary unit :  
If yes, Total number of bed available in the ICCU  
Mention the facilities available in the ICCU :
34. Whether the hospital has post operative care unit in  
each department :  
If yes, Give the details :  
Total number of bed available :  
Mention the facilities available :
35. Whether the hospital has invasive and non-invasive laboratory :  
If yes, Mention the year of installation :  
Facilities available in the labs. :  
Total number of test per month :
36. Whether the hospital has a functional Echo laboratory :  
If yes, Mention the year of installation:  
Make/model of machine  
Name of the person who operate the machine :  
Total number of test per month :
37. Whether the hospital has a functional Treadmill exercise laboratory:  
If yes, Mention the year of installation :  
Make /model of the machine  
Name of the person who operate the machine :  
Total number of test per month :
38. Whether the hospital has a functional Holter laboratory :  
If yes, Mention the year of installation :  
Make/model of meschine  
Name of the person who operate the meschine :  
Total number of test per month :
39. Whether the hospital has a functional cardiac  
catheterization laboratory :  
If yes, Mention the year of starting function :  
Name of the person who operate the machines :  
Total number of cases done in the last 2years :
40. Whether the hospital has a functional ECG laboratory :  
If yes, Number and types of machine used :  
Total number of cases done in the last 2years :
- 41 whether a full fledged post operative intensive care facility  
is available :
42. Whether the staff members are posted for teaching :  
BCVT course :  
If yes, give the details  
Teaching faculties

### **Teaching Faculty**

Sl.No.	Designation	Name	Qualification	Experience	Date of joining	Full/Part time
1	Director					
2	Assistant Professor(Medical)					
3	Instructor					
4	Administrative Officer					
5	Assistant					

Details of equipments available/proposed

- 1) Digital ECG Machines
- 2) Modern Automatic Treadmill Machine —
- 3) Holter Analyzer -
- 4) Standard Quality Echocardiograph —
- 5) Mechanical ventilators —
- 6) Digital Angiographic Equipment —
- 7) Hemodynamic Recorder —
- 8) Hemoximeter —
- 9) patient warmer —
- 10) invasive and non invasive monitors -
- 11) Pressure injector -
- 12) IABP

Give the detailed list of staffs presently available in the concerned department

No	Designation	Name	Qualification	Experience	Date of Joining	Full /Part time

**DECLARATION**

I.....on behalf of the ..... Medical College do hereby state that the information given above is true to the based of my knowledge. Further I do agree to abide by future direction of the State Government Paramedical council regarding mod of selection, minimum standard and fee structure of the proposed course.

Signature of the applicant

Place:

Date:

(Seal)