PUBLIC HEALTH FOUNDATION OF INDIA

ASSOCIATION OF HEALTHCARE PROVIDERS INDIA

CERTIFICATE COURSE IN COMMON MENTAL DISORDERS - (CCCMD)
CYCLE – I (APRIL 2020 – AUGUST 2020)

Participant Enrollment Form

*Name of Participant (In Block Letters) same will be printed on certificate

Father's Name

Gender ☐ Male ☐ Female

*Current affiliation ☐ Private Practice ☐ Central Govt ☐ State Govt

If other, please specify

Medical college/teaching affiliation ☐ Yes ☐ No If yes ☐ State ☐ Center ☐ Private

Location of practice ☐ Rural ☐ Urban

*Communication address

Place of work

Street Nearest landmark

City *District State

*Pin code STD code Phone

If, same as above ☐

Residence

Street Nearest landmark

City *District State

*Pin code STD code Phone

Preferred mailing address ☐ Place of work ☐ Residence

*Mobile No Alternate No

*Email address

Alternate Email address

*Mandatory to be filled

CERTIFICATE COURSE IN COMMON MENTAL DISORDERS

*Date of birth D D M M Y Y Y Y

Type of registration ☐ MCI ☐ State Medical Council

Specify your registration number

*Medical council registration number

Date D D M M Y Y Y Y State

*Educational/Academic/Technical/Professional Qualification (Attach Proof)

Qualification	College/Institution/Board/University	Dept	Year
MBBS			
MD/MS/DNB			
DM			
PhD			
Diploma			
Any other			

Total professional/clinical experience Years

Total years of experience in dealing with mental disorders and management Years

Average number of patients treated per month

Out of all patients treated by you, how many patients suffering from mental disorders

Details of Experience

Designation	Organization	From..... To....

Any additional information(publication/presentation/awards/scientific scholarship if any)

Please indicate motivation and benefits you foresee in undergoing this course..

DECLARATION

I hereby declare that the above mentioned information, which I have provided, is true to the best of my knowledge. I shall participate in the contact sessions organised once in a month on Weekend and will devote self-reading time for the entire five modules and participate in the assessments, organised by the offering institution. I also give my consent for publishing my feedback/testimonial which I will provide to the Secretariat in any report or publication produced by PHFI. I understand that CCCMD is not a degree but a certificate course with the objective of training doctors in prevention and management of common mental disorders and successful participants are not entitled to mention/call themselves as Psychiatrists anywhere after completion of this course. I also understand that this certificate course is not a recognised Medical Qualification, under section 11 (1) of the Indian Medical Council Act 1956 and the Institution offering this course is neither a medical college or a university nor offering the course in accordance with the provisions of the Indian Medical Act/University Grants Commission Act.

Signature

Date

Name

Place

PREFERENCE OF CENTRE

(Subject to the availability of seats) *

Preferred Faculty

Preferred Centre

* **In case of non availability, CCCMD secretariat will contact you for alternate options**

PAYMENT OPTIONS

NEFT DETAILS FOR ONLINE PAYMENT

PUBLIC HEALTH FOUNDATION OF INDIA

Account Branch : HDFC BANK LIMITED

Address : H-7, GREEN PARK EXTENSION, NEW DELHI

Account No : 50100254381662

RTGS/NEFT IFSC : HDFC0000586

PAN No. : AABAP4445L

OR

PAYMENT THROUGH DEMAND DRAFT

Payment of **₹ 10,000/-** should be in favour

PUBLIC HEALTH FOUNDATION OF INDIA

payable at New Delhi

"In case of NEFT transaction, kindly mention CCCMD course fee in payment remarks"

Check list of attachments with this application form (Please √ tick)

1. Passport Size Photograph ☐
2. Date of Birth Proof (High School Certificate/ PAN Card/ Passport/ Driving License) ☐
3. MCI/ State Council Registration Certificate ☐
4. MBBS Degree Certificate ☐
5. MD, MS, DM, DNB, Ph. D – Degree (whichever is applicable, please attach all if applicable) ☐
6. Any other additional certificate or fellowship in Psychiatry ☐
7. Experience certificate ☐
8. Mode of Payment: ☐ NEFT ☐ Demand Draft

NEFT Reference No./DD No _____ Date DD MM YYYY

Name of Bank &Branch _____

Please mail this form along with the required documents to:

CCCMD
Certificate Course in
Common Mental Disorders

Program Secretariat- CCCMD
Public Health Foundation of India
Plot No.47, Sector - 44, Gurugram, Haryana – 122002, India
Email: chronicconditions@phfi.org, Website: www.mentalhealthedu.org
Mob: +91- 9555819865, 9650754333, Ph: 0124-4781400 (Ext: 4513,4509)