KERALA UNIVERSITY OF HEALTH SCIENCES
THRISSUR – 680 596
INSPECTION PROFORMA FOR CONTINUATION OF PROVISIONAL AFFILIATION
(B.Sc. Optometry)

DETAILS OF INSPECTORS
Inspection Date :
Name of the Inspector (1) :
Designation :
Address :
Contact No. :
E mail ID
:
Name of the Inspector (2) :
Designation :
Address :
Contact No. :
E mail ID :
Order No. And date in which :
inspection committee was appointed

1.Name and Address of the Applicant/Institution /Trust/Society:

(With Phone No.,Email ,Fax)

2.Whether the agency is a registered society :

(Attach copy of registration certificate)

3. Name of the Village,Taluk and District in which the Institute is proposed :

4.Website address of the institute:

5.Total Area of the building

(attach copy of approved plan)

6.Area of land (attach copies of document) :

7.Registered owner of the land. :

8.Land description and exact location of the land

(Enclose the plan of the land with road map) :

9.Whether no objection certificate obtained from the local bodies :

(If yes, attach the copies of no objection certificate)

10.Name of the course applied for:

11.Number of seats proposed :

12.Details of other Medical or Paramedical courses conducted by the college :

Sl.No	Name of the course	Year of starting	Number of students per batch	Detail of letter of permission from University

13. Name of the Head of Institution

Designation :

Qualification :

Phone No. :

Mobile No. :

Fax :

E mail :

14.Whether the Institute has own Hospital in the premises :

If yes,

a) When the hospital started function :

b) Area of land :

c) Name of the owner :

d) Total working space available :

(Attach the copy of approved plan)

Total no of in-patient/month :

(attach necessary documents for the same)

f) Total number of out patient/month :

(attach necessary documents for the same)

g) Number of beds :

(Attach memorandum of understanding/permission letter from head of the hospital between the hospital and institution regarding training facility for the students in clinical subjects in the hospital)

15.Whether the attached hospital has specialty departments (including clinical/paraclinical/nonclinical depts.):

If yes, give details

SNo	Name of the specialties	Year of starting	Number of out patients/yr	No. of inpatients/yr

16.1. DETAILS OF TEACHING STAFF FOR BASIC SUBJECTS(Non- Medical)

Name of the Occupant	Designation	Qualification	Experience	Subject-Teaching	Full time/Part time

(Attach separate list of faculties stating the Designation, Qualification, Experience, date of joining, whether exclusively for the course and with their signature)

2. DETAILS OF TEACHING FACILITIES FOR THE MEDICAL SUBJECTS

Name of the subject	Semester of training	Number of theory classes/year	Practical/laboratory Experience-total no. of hours/year

(Attach details of lectures and practical training for the relevant period)

3.DETAILS OF OPHTHALMOLOGY DEPARTMENT FACILITIES IN THE HOSPITAL:

a) Total Outpatients/day:

b) Total Inpatients/day:

c) Total No. Of Operation theatres:

d) No. Of Surgeries conducted / month(Attach details regarding type of surgeries)

e) Total no. and designations of Ophthalmologists:

f) Details of other staff:

17. Whether the institute has an Auditorium to conduct Common student's functions/examinations/seminars :

If yes, Total number of students in the institute :

Total working Area of auditorium :

How many students can be occupied? :

Facilities in the auditorium :

18. Whether the institute has Common room for boys /Girls :

If yes, Total working area :

Facilities available in the common room (including separate toilet facilities):

19.Whether the institute has a Library :

Total area/seating capacity :

Facilities available in the library :

Number of books/journals available(Enclose details)

Availability of Internet :

Timings:

Annual Budget of Library:

20. Whether the institute has Hostel facility for boys and girls:

21. Teaching facilities:

a. Whether sufficientno. of Lecture halls present:

b. Audiovisual and Teaching Aids details:

c. Total number of seating arrangements/class :

d. Faculty rooms/common rooms:

22. Remarks regarding the conduct of the course

1) No. of students present in the first year :

2) No. of students present in the second year

3) No. of students present in the third year

23. OPTOMETRY COURSE TRAINING DETAILS (relevant for the year of inspection)**:**

a. Details of theory classes taken:

b. Practical Training/speciality training:

c. Details of Labs for Optometry with Instrumentation:

d. Details of Internal Examinations conducted:

e. Attendance Details of Students and Faculty:

f. List of Projects undertaken with name of student and supervising faculty:

h. Maintenance of Practical Records and Log Book

24. Feedback from the students

1) Theoretical training :

2) Practical training :

3) Hospital posting

4) Conduct of Examination :

5) Hostel / Food :

6) Transportation :

25. Specific Remarks of the Inspectors

Name, Designation and Signature of Inspectors with date

1) …….

2) …….

INSPECTION PROFORMA B- FACULTY DETAILS

TEACHING FACULTY

Sl. No	Designation	Name	Subject	Qualification	Experience	Date of joining	Full/Part time	Details of medical/para medical council Registration	Signature of faculty with date(to be signed in the presence of inspector)

OTHER STAFF DETAILS:

Sl.No	Designation	Name	Qualification	Date of joining
1.	Administrative officer			
2.	Office Assistant			
3.	Office Assistant			
4.	Lab Assistant			
5.	Lab Assistant			

DECLARATION I……on behalf of the ……. Institution, do hereby state that the information given above is true to the best of my knowledge. Further I do agree to abide by future directions of the Kerala University of Health Sciences regarding mode of selection, minimum standard and fee structure of the proposed course.

Signature of the applicant

Date Seal

Countersigned by inspector

Place:

Date:

NAME OF THE COLLEGE : _____

Date of Assessment

Name of the Assessor

Signature of Assessor