

**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.

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: