

FOR FELLOWSHIP CERTIFICATE COURSE(S) A.Y. 2024 – 2025.

(As per provision of the Maharashtra university of Health Science Act, 1998 University Rule/Guidelines)

Date of Inspection	
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1) Name(s) of the fellowship/Certificate Course(S)

Sr. No.	Name of the Fellowship /Certificate Course	Course Started form the Academic Year	Intake Capacity Sanctioned by the University	Name of Mentor and Contact Details
1	NA	---	---	---
2	NA	---	---	---
3	NA	---	---	---
4	NA	---	---	---
5	NA	---	---	---
6	NA	---	---	---
7	NA	---	---	---

2) Year –wise number of students admitted to fellowship course during last 5 years.

Sr. No.	Academic Year	Name of Fellowship/Certificate Course	Intake Capacity	No. of Students Admitted (in figure only)
1	A.Y. 20 - 20	---	---	---
2	A.Y. 20 - 20	---	---	---
3	A.Y. 20 - 20	---	---	---
4	A.Y. 20 - 20	---	---	---
5	A.Y. 20 - 20	---	---	---



B. V. Kale
PRINCIPAL
 Late Babruwan Vitthalrao Kale
 Ayurved Medical College & Hospital
 Gandhi Maidan, Latur

Information to be submitted with respect to newly appointed mentors
Professional Teaching Experience Certificate for fellowship/Certificate Courses
Director/Mentor

Title of the Course applied for-----

This is Certify that Dr. -----

Department of -----Training Center as per following details.

A) General Experience

Designation	Form	To	Total period Year/Months	
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B) Actual Experience in the subject of concerned Fellowship/Certificate course applied for:-

Designation	Form	To	Total period Year/Months	
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(It is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in the Subject of concerned fellowship/certificate course)

Sign & Stamp
 Head of the Department
 Date. / /

Sign & Stamp
 Dean/Principal/Head of Institute
 Date. / /

Name of Inspectors		Signature of Inspectors
1	Chairman	
2	Member	
3	Member	
4	Member	




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