Dr.Niteen Ghorpade's Inspiria LAPAROSCOPY & IVF RESEARCH CENTRE

Inspiria Laparoscopy & IVF Research Centre

Nagar-Manmad Road, Near Kundan Petrol Pump, Rahata, Ahmednagar, Maharashtra – 423107 (IN)

Application for Fellowship

Name: Dr. _____

Qualification: _____

Contact No: _____

e-mail id: _____

Fellowship Program Selected:

1. One Month
2. 3 Months
3. 6 Months
4. 1 Year

Expected Fellowship Dates:

Start Date:

End Date:

Terms & Conditions:

- Candidate has to ensure that he is having all required approvals and credentials required for performing surgeries as per regulations.
- Allocated dates may change as per available fellowship slots and candidate agrees to accommodate as per allocated dates.
- Once available slots are communicated to candidate, candidate needs to confirm his booking by paying 40% fees and slots will be allocated on first come first basis.
- Booking amount paid is completely non-refundable and In the event of cancellation of booked fellowship dates by candidate, they are not entitled for any claim of refunds.

- Candidate need to report on date of allocated fellowship start date and, in the event, to fail to report on start date, his/her allocation will be deemed to be cancelled and slot will be allocated to next waiting list candidate.
- Candidate will be allocated cases as per agreed number of cases for each fellowship program duration. Efforts will be made to uniformly distribute cases uniformly over fellowship duration but this is solely dependent on availability of cases and in the event of availability of more cases, candidates may finish his allocated cases earlier than his agreed fellowship duration.
- Candidate need to make his own arrangements of stay and food, coordinator from Inspiria will support candidates for settling down completely on voluntarily basis.

I Dr. _____ _____ _____ hereby confirm that I have gone through all terms & conditions regarding fellowship program and I am willingly applying for this fellowship program.

Transaction Details of Booking Amount Paid:

UTR No:

Amount Paid

Date:

Place:

Date:

Signature:

Name: Dr. _____