NAME OF THE COLLEGE: KERALA MEDICAL COLLEGE

Date of Assessment		Remarks
Accepted? (YES/NO)		
Name of the Assessor		
Signature of Assessor		

DECLARATION FORM : 2017 – 2018 - FACULTY

1.(a) Name Dr ARUN ARAVIND

1.(b) Date of Birth & Age 23-12-1978 37yrs

1.(c) Submit Photo ID proof issued by Govt. Authorities :
Photo ID submitted :
Passport copy / PAN Card / Voter ID / Aadhar Card

Number 745661586103 Issued by Government of INDIA

Note: 1) Without Photo ID, Declaration form will be rejected and will not be considered as teaching faculty. 2) Original Certificates are mandatory for verification. All Certificates/Documents/Certified Translations, must be in English

1.(d) i. Present Designation: ASSISTANT PROFESSOR

1.(d)(i)a Certified copies of present appointment order at present institute attached.

1.(d)ii. Department: MICROBIOLOGY

1.(d) iii. College: KERALA MEDICAL COLLEGE

1.(d)iv. City: CHERPULASSERY

1.(d) v. Nature of appointment: (Regular) / Contractual.

1.(d)vi. Date of appearance in Last MCI – UG/PG/Any Other Assessment _____

1.(d)vii Whether appeared in Last MCI – UG/PG Assessment in the same Institute – Yes/No

1.(d)viii Whether appeared in Last MCI – UG/PG Assessment on same Designation – Yes/No

1.(e) Residential Address of employee : KODANGADAN APARTMENTS
CHERPULASSERY.

Signature of Faculty

Signature of Head of the Institution
PRINCIPAL
Kerala Medical College
Cherpulassery, Pala-679503

1.(f) Have you undergone Training in "Basic Course Workshop" at MCI Regional Centre in MET *or in your college under Regional Centre observership*?

Yes ☐ No ☑

If yes, *give details.*

Name of MCI Regional Centre where Training was done/*If training was done in college, give the details of the observer from RC*	Date *and place* of training

1.(g) **Copy of Passport /Voter Card / Electricity Bill /Landline Telephone Bill / Aadhar Card / attached as a proof of residence. Yes/No**

1.(h) Contact Particulars: Tel (Office): 0486 2208102 (with STD code)

Tel (Residence): _____ (with STD code)

E-mail address: dravunaravind@gmail.com

Mobile Number: 8129522544

1. (i) Date of joining present institution : 27-10-2016 as Assistant Professor

1. (j) Joining report at the present institute attached - Yes/No

2. Qualifications :

Qualification	College	University	Year	Registration No. of UG & PG with date	Name of the State Medical Council
MBBS	ACADEMY OF MEDICAL SCIENCES	KANNUR UNIVERSITY	2006	36625 UG 21.05.2009 PG 10.08.2016	TRAVANCORE COCHIN MEDICAL COUNCIL
MD/MS/DNB /PhD ( )	AMRITAPURI UREPU MEDICAL COLLEGE	VINAYAKA MISSION UNIVERSITY	2016	36625 10.08.2016	TRAVANCORE COCHIN MEDICAL COUNCIL
DM/M.Ch. ( )					

Note: For PG-Post PG qualification additional Registration certificate particulars be furnished and subject be indicated within brackets after scoring out whichever is not applicable.

2. (a) **Copy of Degree certificates of MBBS and PG degree attached – Yes/No**

2. (b) **Copy of Registration of MBBS and PG degree attached – Yes/No**

3 (a). Details of the teaching experience till date.

Designation	Department	Name of Institution	From DD/MM/YY	To DD/MM/YY	Total Experience in years & months
Junior Resident					
Senior Resident					
Tutor	Microbiology	AVMC	April 2013	April 2016	3 yrs.
Assistant Professor	"	KMC	27/10/16	Till date	
Associate Professor					
Professor					

Note:- Tutor working in Anesthesia and Radio-diagnosis must have 3 years teaching experience in the respective departments in a recognized/permitted medical institute to be consider as senior resident.

3(b). To be filled in by Ex Army Personnel only:

S.No.	Designation	Institution	Period	
			From	To
1.	**Graded Specialist**			
2.	**Classified Specialist**			
3.	**Advisor**			

Note: Have you been considered in any UG/PG inspection at any other institution/ medical college during last 3 years. If yes, please give details.

_____

_____

_____

4 .(a) Before joining present institution I was working at _____ as _____ and relieved on _____ after resigning / retiring (**Relieving order is enclosed from the previous institution**).