

## Professional Teaching Experience Certificate for Fellowship/Certificate Courses

Director/Mentor

Title of the Course applied for: *fellowship course in minimal Access surgery-Gynaecology*This to Certify that Dr. *Chaitanya Shembekar* has worked in the Department of *Shembekar Hospital Pvt. Ltd.* Training Centre as per following details

## A) General Experience

Designation	From	To	Total period Year/Months	
<i>Registrar</i>	<i>1993</i>	<i>1995</i>	<i>2 yrs</i>	
<i>Asst. Prof</i>	<i>1995</i>	<i>1997</i>	<i>2 yrs</i>	

## B) Actual experience in the subject of concerned Fellowship/Certificate Course applied for :-

Designation	From	To	Total period Year/Months	
<i>Fellow guide &amp; mentor</i>	<i>2016</i>	<i>2025</i>	<i>9 yrs</i>	

(It is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in the Subject of concerned Fellowship/Certificate Course)

Sign &amp; Stamp

Head of the Department

Date *23/8/25*

*Asst. Prof*  
**DR. C. A. SEMBEKAR**  
 M. D.  
 OBSTETRICIAN & GYNAECOLOGIST  
 REG. No. 67862



Sign &amp; Stamp

Dean/Principal/Head of Institute

Date *23/8/25*

*Asst. Prof*  
**DR. C. A. SEMBEKAR**  
 M. D.  
 OBSTETRICIAN & GYNAECOLOGIST  
 REG. No. 67862





**Professional Teaching Experience Certificate for Fellowship/Certificate Courses**  
**Director/Mentor**

Title of the Course applied for:- *Fellowship courses in minimal Access Surgery Gynaecology*

This to Certify that Dr. *Chaitanya Shembekar* ..... has worked in the Department of *gynaecology hospital Pvt. Ltd* ..... Training Centre as per following details

**A) General Experience**

Designation	From	To	Total period Year/Months
<i>Resident</i>	<i>1993</i>	<i>1995</i>	<i>2 yrs</i>
<i>Asst. Prof</i>	<i>1995</i>	<i>1997</i>	<i>2 yrs</i>

**B) Actual experience in the subject of concerned Fellowship/Certificate Course applied for :-**

Designation	From	To	Total period Year/Months
<i>fellow guide &amp; mentor</i>	<i>2016</i>	<i>2025</i>	<i>9 yrs</i>

(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 *hsh*  
 Head of the Department  
 Date *23/8/25*  
**DR. C. A. SHEMBEKAR**  
 M. D.  
 OBSTETRICIAN & GYNAECOLOGIST  
 REG. No. 67862



Sign & Stamp *hsh*  
 Dean/Principal/Head of Institute  
 Date *23/8/25*  
**DR. C. A. SHEMBEKAR**  
 M. D.  
 OBSTETRICIAN & GYNAECOLOGIST  
 REG. No. 67862



**Professional Teaching Experience Certificate for Fellowship/Certificate Courses  
Director/Mentor**

Title of the Course applied for:- *fellowship course in Assisted Reproduction Techniques*

This to Certify that Dr. *Chaitanya Shembekar* has worked in the Department of *Shembekar Hospital Pvt. Ltd* Training Centre as per following details

**A) General Experience**

Designation	From	To	Total period Year/Months
<i>Registrar</i>	<i>1993</i>	<i>1995</i>	<i>2 yrs</i>
<i>Asst. Prof</i>	<i>1995</i>	<i>1997</i>	<i>2 yrs</i>

**B) Actual experience in the subject of concerned Fellowship/Certificate Course applied for :-**

Designation	From	To	Total period Year/Months
<i>Fellow guide &amp; mentor</i>	<i>2016</i>	<i>2025</i>	<i>9 yrs</i>

(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

*23/8/25*  
**DR. C. A. SEMBEKAR**  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST  
REG. No. 67862



Sign & Stamp

Dean/Principal/Head of Institute

Date

*23/8/25*  
**DR. C. A. SEMBEKAR**  
M. D.  
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REG. No. 67862



**Professional Teaching Experience Certificate for Fellowship/Certificate Courses**

**Director/Mentor**

Title of the Course applied for:- *Fellowship course in Assisted Reproduction Technique*

This to Certify that Dr. *Chaitanya Shembekar* has worked in the Department of *Shembekar Hospital Pvt. Ltd.* Training Centre as per following details

**A) General Experience**

Designation	From	To	Total period Year/Months
<i>Registree</i>	<i>1993</i>	<i>1995</i>	<i>2 yrs</i>
<i>Asst. Prof</i>	<i>1995</i>	<i>1997</i>	<i>2 yrs</i>

**B) Actual experience in the subject of concerned Fellowship/Certificate Course applied for :-**

Designation	From	To	Total period Year/Months
<i>Fellowship 8 months</i>	<i>2016</i>	<i>2025</i>	<i>9 yrs.</i>

(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

*23/8/25*

*DR. C. A. SHEMBEKAR*  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST  
REG. No. 67862



Sign & Stamp

Dean/Principal/Head of Institute

Date

*23/8/25*

*DR. C. A. SHEMBEKAR*  
M. D.  
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REG. No. 67862



## (INSTITUTIONAL INFORMATION)

## 1. Particulars of Director / Dean / Principal: (Who so ever is Head of Training Centre)

Name: Dr. Chaitanya Shembekar Age: 56 yrs (Date of Birth) 03-08-1969

PG Degree	Subject	Year	Institution	University
Recognized / Not Recognized	<u>obgy</u>	<u>1995</u>	<u>GMC, Nagpur</u>	<u>Nagpur University</u>

## Teaching Experience

Designation	Institution	From	To	Total Exp.
Asst. Professor	<u>GMC, Nagpur</u>	<u>1995</u>	<u>1997</u>	<u>2 yrs</u>
Asso. Professor/Reader				
Professor				<u>2 yrs</u>
Any Other	<u>Registrar GMC, Nagp</u>	<u>1993-95</u>	Grand Total	<u>4 yrs</u>

## 2. Management/Society/Inst. Information:

01	i) Name of the Society/Institution/ Training Centre /University Dept.:	<u>Shembekar Hospital Pvt. Ltd</u>
	ii) Postal Address, with PIN:	<u>53, LIC Colony, Khamta Road, Nagpur-440015</u>
	iii) Contact Details:	Mob: <u>9822572744</u> Tele: <u>8369283713</u>
02	Society/Institution/ Training Centre Registration Number and date: Teaching Experience	i) Public Trust Act 1950: .....
		ii) Society's Registration Act. 1860: .....
		iii) Year of establishment: <u>Pvt. Ltd. since 2009</u>
		iv) Copies of Registration, Constitution and Memorandum of Association attached? *Yes/No- Marked as Appendix 'A'
03	Hospital Information : (It is mandatory for Training Centre/applying Institute to have their own functional Hospital as per norms )	
	i) Name of the Hospital	<u>Shembekar Hospitals Pvt. Ltd</u>
	ii) Nursing Home Registration No. iii) Establishment Year	<u>955</u> <u>12-6-2015</u> - Mark as Appendix 'B'
04	i) Name of the Training Centre /Institute where course is to be conducted:	<u>Shembekar, Hospital Pvt. Ltd</u>
	ii) Postal Address, with PIN:	<u>53, LIC Colony, Ajni Chok, Khamta Road</u>
	iii) Contact Details:	Mob: <u>9822572744</u> Tele: <u>Nagpur</u>
	iv) E-mail ID:	<u>chaitanyashembekar@yahoo.com</u>
	v) List of University approved Fellowship/Certificate Course(s) conducted / already running at Training Centre with Intake Capacity	Name of the Course(s) <u>Minimal Anesth. Suleqey-Gunae</u> Approved Intake Capacity <u>02/02</u> Affiliated Since... (if necessary Attach separate List) <u>2016-2017</u>
	vi) Training Centre / Institute willing/desirous to Start/Open Fellowship/Certificate Course(s) (For New Opening Purpose only)	Name of the Course(s) ..... Required Required Intake Capacity.....(if necessary Attach separate List) <u>N.A</u>
05	Affiliation Fees details: (Bank/DD no./ date/amount/ NEFT/RTGS)	Paid Fees details Attached: <input checked="" type="checkbox"/> Yes/No. (Pending Fees, if any ;)
06	Financial position of the Society/ Institute in the preceding 03 years:	Audited Statements of Accounts for *Yes/No- Mark as Appendix 'C'
07	Budgetary provision for the FC/CC/DC for the next 03 years	i) 2024-25 Rs ..... <u>4.5 lakhs</u>
08	Management Resolution seeking Recognition of Institute for FC/CC/DC of MUHS, Nashik:	Resolution No. .... Dated .....
		Copy of Management Resolution attached?
		<input checked="" type="checkbox"/> *Yes/No- Mark as Appendix 'D'

09	<b>Other Information:</b>	
	a) Land:	<input checked="" type="checkbox"/> *Yes/No. If yes, then Area: <u>6000... squ. feet</u>
	i) Whether the land is owned by the Applicant Institute/Training Centre/Trust:	Copy of land documents i.e. 7/12 extract, Property Card, etc. attached? <input checked="" type="checkbox"/> *Yes/No— Mark as Appendix 'E'
	ii) Whether the land is registered?	*Yes/No. If yes, Registration Number: ..... Dated ..... At (Place): ..... Copy of Land Registration Certificate attached? *Yes/No.— Mark as Appendix 'F'
	iii) Any loans, mortgage, etc. shown against the title of the land:	*Yes/No. If yes, amount of loan Rs. /mortgaged for Rs. .... Copy of Loan/Mortgage Deed attached? *Yes/No. — Mark as Appendix 'G'
b) Building:	..... sq. ft.	
i) Total built-up area:	Certified copy of Building Plan attached? <input checked="" type="checkbox"/> *Yes/No — Mark as Appendix 'H'	

**3. Central Library**

- Total number of Books in library: 1850

- Books pertaining to concerned Fellowship subject: 560

- Purchase of latest editions of concerned books in last 3 years: - 190

- Journals:

1	Journals	Total	concerned Fellowship subject
2	Indian	<u>19</u>	<u>9</u>
3	Foreign	<u>17</u>	<u>5</u>

- Year / Month up to which latest Indian Journals available : July '25

- Year / Month up to which latest Foreign Journals available : Sep '24 & Aug '25

- Internet / Med pub / Photocopy facility: available / not available

- Library opening times: 8 am - 8 pm

- Reading facility out of routine library hours: available / not available

(Obtain list of books & journals duly signed by Dean)

**4. Recreational facilities:**

Available / Not available

- Play grounds  Gymnasium

5. **Hostel Accommodation:**

Particular	UG		PG		Interns	
	Boys	Girls	Boys	Girls	Boys	Girls
No. of Rooms No. of	-	-	3	3	-	-
Students	-	-	1	1	-	-
Status of Cleanliness	-	-	good	good	-	-

6. **Residential accommodation for Staff / Paramedical staff :** Available / Not Available

7. **Ethical Committee (Constitution) :**

YES / NO

Attached to IEC,  
panoli  
Mangalore

8. **Medical Education Unit (Constitution) :**

YES / NO

(Specify number of meetings held annually & minutes thereof)

9. **Any other faculty specific information required :**

(such as Herbal garden / Panchakarma Unit/Pharmacy / Dental Chairs and Units/as per the requirement of concerned Course) Attach details)

pharmacy → outsourced (present in premises)

**5. Casualty:/ Emergency Department :**

Space	2000 sq. feet
Number of Beds	4
No. of cases (Average daily OPD and Admissions):	90-95 & 10-12
Emergency Lab in Casualty (round the clock):	available / not available
Emergency OT and Dressing Room	yes
Staff (Medical/Paramedical)	yes
Equipment available	yes

**6. Blood Bank :** H-A-C MOUT Blood Bank within 2 km)

(i)	Valid FDA License(copy of certificate be annexed)	Yes / No	
(ii)	Blood component facility available	Yes / No	
(iii)	All Blood Units tested for Hepatitis C,B, HIV	Yes / No	
(iv)	Nature of Blood Storage facilities (as per specifications)	Yes / No	
(v)	Number of Blood Units available on inspection day		
(vi)	Average blood units consumed daily and on inspection day in the entire Hospital ( give distribution in various specialties)	Average daily	On Inspection day

**7. Central Laboratory:**

- Controlling Department: outsourced
- No of Staff : \_\_\_\_\_
- Equipment Available : Attach separate List \_\_\_\_\_
- Working Hours: \_\_\_\_\_

**8. Central supply of Oxygen / Suction:**

Available /  Not available

**9. Central Sterilization Department**

Available /  Not available

**10. Ambulance (Functional)**

Available /  Not available (outsourced)

**11. Laundry:**

Manual/ Mechanical/ Outsourced

**12. Kitchen**

Available /  Outsourced /  Not Available

**13. Incinerator: Functional / Non functional**

Capacity ..... /  Outsourced

**14. Bio-Medical waste disposal**

Outsourced / any other method

**15. Generator facility**

Available /  Not available

**16. Medical Record Section:**

- ICD X classification

Computerized /  Non computerized  
 Used /  Not used

Sign & Stamp

Head of the Department

Date: 23/8/25 *Handwritten signature*

**DR. C. A. SHEMBEKAR**  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST  
REG. No. 67862



Sign & Stamp

Dean/ Principal/ Director of Training Centre

*Handwritten signature*  
**DR. C. A. SHEMBEKAR**  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST  
REG. No. 67862

Training Centre Round Seal



## HOSPITAL INFORMATION

1. Name of the Hospital: Shembekar Hospitals Pvt. Ltd.

2. Total number of OPD, IPD in the Institution and concerned department during the last one year:

In the entire hospital		In the department of concerned Fellowship subject	
OPD	30000	OPD	18000
IPD (Total No. of Patients admitted)	5800	IPD (Total No. of Patients admitted)	4000

3. Hospital Beds Distribution & No of O.T.:

In the entire hospital	
No of Beds	31
No of Beds in ICU	2
No of Beds in IRCU	—
No of Beds in SICU	2
No of Major O.T.	2
No of Minor O.T.	1

4. Available Clinical Material: (Give the data only for the department of concerned Fellowship subject)

No. of available for clinical service on inspection day:	On Inspection day	Average of random 3 days
• Daily OPD – 2 PM	.....	.....
• Daily admissions	.....	.....
• Daily admissions in Dept.	.....	.....
• Through casualty at 10am • Bed occupancy in the Dept.	.....	.....
• Number of patients in ward (IPD) at 10AM	.....	.....
• Percentage bed occupancy at 10Am	.....	.....

• Clinical Procedure(s) & Operative Details related to Fellowship subject/Specialty :

(For further details in this concern, kindly peruse the Guidelines information sheet supplied herewith)

On Inspection day

Average of random 3 days

•	.....	.....
•	.....	.....
•	.....	.....
•	.....	.....
•	.....	.....

## DEPARTMENTAL INFORMATION

(If required Use Separate Sheet for each Department / Fellowship/Certificate Course)

1. Fellowship Specialty Department to be inspected: Assisted Reproduction Techniques  
 2. Date on which independent department of: functioning concerned specialty was created and started  
 ..... 16/6/2007 .....

3. Mentor's details (From start of department till date) :

Sr. No.	Name	Full Time/ Part Time	Designation	Qualification	Experience in Yrs. (after acquiring PG Qualification in concerned Subject)
11	Dr. C. Shembekar	Full Time	Consultant	MP (Obgy)	27 yrs.

4. Whether Independent Department of concerned Fellowship subject exists in the Institution :  
 Yes/No: ..... Since when: 16/6/2007

5. Specialty Department Infrastructure Details :

Facility	Area (sft.)	Available	Not Available
Faculty rooms	200	yes	
Clinics	306	yes	
Laboratory Space	outsourced	yes	
Seminar room	200	yes	
Department Library	300	yes	
PG common room	200	yes	
Pre-clinical lab (where ever applicable)	N.A		
Patient waiting room	500	yes	
Total area	3500		

6. If course already started, year wise number of students admitted and available Mentors to teach students admitted to Fellowship / Certificate Course during the last 3 years:

Year	Name of the Course	No. of students admitted	No. of Valid Mentors available in the dept. (give names)
1)	Fellowship course in		
2	Assisted Reproduction Techniques	02	Dr. C.A. Shembekar Dr. M. Shembekar

(Local Inquiry Committee shall specifically ensure about availability of eligible/validated Mentor(s) and shall check whether the Training Center met with the Student: Mentor Ratio for the permitted Intake Capacity for each course or else it shall be reported in the Overall Remark Option.)

7. List of Non-teaching Staff in the department:

Sr. No.	Name	Designation
11	Pratima Meshram	OT Incharge
	Divya Hede	OT Technician
	Amal Selekars	OT Technician

8. List of Equipment(s) in the department of concerned Fellowship subject: Equipment's: List of Important equipment's available and their functional status (List here only- No annexure to be attached)

Sr. No.	Name of the Equipment	Specification	Functional / Not Functional	Qty.
				4

DEPARTMENTAL INFORMATION

(If required Use Separate Sheet for each Department / Fellowship/Certificate Course)

1. Fellowship Specialty Department to be inspected: *minimal access surgery - by need*
2. Date on which independent department of: functioning concerned specialty was created and started ..... *16/6/2007*
3. Mentor's details (From start of department till date) :

Sr. No.	Name	Full Time/ Part Time	Designation	Qualification	Experience in Yrs. (after acquiring PG Qualification in concerned Subject)
1)	Dr. C. Shembekar	full time	consultant	M.D(OBGYN)	24 yrs.

4. Whether Independent Department of concerned Fellowship subject exists in the Institution : *Yes/No* Since when:

5. Specialty Department Infrastructure Details :

Facility	Area (sft.)	Available	Not Available
Faculty rooms	200	yes	
Clinics	300	yes	
Laboratory Space	outsourced	yes	
Seminar room	200	yes	
Department Library	300	yes	
PG common room	200	yes	
Pre-clinical lab (where ever applicable)	N.A		
Patient waiting room	500	yes	
Total area	3500		

6. If course already started, year wise number of students admitted and available Mentors to teach students admitted to Fellowship / Certificate Course during the last 3years:

Year	Name of the Course	No. of students admitted	No. of Valid Mentors available in the dept. (give names)
	Fellowship course in minimal Access surgery	02	Dr. C. A. Shembekar Dr. M. Shembekar

(Local Inquiry Committee shall specifically ensure about availability of eligible/validated Mentor(s) and shall check whether the Training Center met with the Student: Mentor Ratio for the permitted Intake Capacity for each course or else it shall be reported in the Overall Remark Option.)

7. List of Non-teaching Staff in the department:

Sr. No.	Name	Designation
1)	Beetima Meshram	OT Technician
2)	Vinod Shende	OT Technician
3)	Dhruv Babhane	OT Technician

8. List of Equipment(s) in the department of concerned Fellowship subject: Equipment's: List of Important equipment's available and their functional status (List here only- No annexure to be attached)

Sr. No.	Name of the Equipment	Specification	Functional / Not Functional	Qty.

9. Intensive care Service provided by the Department: (Emergency) **yes**

10. Specialty clinics being run by the department and number of patients in each :

Sr. No.	Name of the clinic	Days on which held	Timings	Average No. of cases attended	Name of Clinic In-charge
1	Infertility	mon-sat	11 AM	60-65	Dr. C. Shembekar
2	Antenatal	mon-sat	6 PM	50-60	Dr. Paul Saoji

11. Services provided by the Department:

a) Services

i. **Infertility**

ii. **Antenatal clinic**

iii. **Gynecology, menopause, colposcopy, gynaecology clinic**

(b) Ancillary Services

(f) Others: **fertility counselling Adolescent clinic**

12. Space:

Sr. No	Details	In OPD	In IPD
1	Patient Examination/ Checking Arrangement	yes	yes
2	Equipment's	yes	yes
3	Teaching Space	yes	yes
4	Waiting area for patients	yes	yes

13. Office space:

Department Office		Office Space for Teaching Faculty	
Space (Adequate)	Yes/No	HOD	yes
Staff (Steno /Clerk).	Yes/No	Professors	yes
Computer/ Typewriter	Yes/No	Associate Professors	yes
Storage space for files	Yes/No	Assistant Profess or	yes
		Residents	yes

14. Clinical Load of Dept.: No of Surgeries / Procedures **79** Per day

15. Submission of data to National Authorities if any : **data submitted to Deegna Municipal Corporation**

### Information of Director of Training Centre

It shall be verified by the Head of the concerned Training Center,

Sr. No.	Particular	Information to be filled
01.	Name of the Director	Dr. Chaitanya Shembekar
02.	Date of Birth	03-08-1969
03.	Address	21, Ramkrishna Nagar, Khamda Road, Nagpur
04.	Tel. No./ Mob. No.	9822572744
05.	E-mail id	ChaitanyaShembekar@yahoo.com
06.	Nationality	Indian
07.	Qualification in details : (attach documentary proof)	MD (Obgy)
08.	Teaching Experience / Health Sciences: Profession Experience (Attached document proof with signature of Head of the Institute. Also it is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in the Subject of concerned Fellowship/Certificate Course)	Registee - 1993-95 Asst prof - 1995-97 guide → 2016-2025
09.	Present Appointment	managing Director & consultant
10.	Publications (List & Proof)	Attached
11.	Post Graduate Teaching experience (Attach documentary evidence)	5425
12.	Any other relevant information	—

Date: - 23/8/2025

For the use of affiliated Training Center:

I have verified the eligibility of the above Director as per the criteria of eligibility prescribed by the University vide clause no.7 of the University Direction No. 05/2017 (Amended).

Name & Sign. of Director  
**DR. C. A. SHEMBEKAR**  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST.

Sign & Stamp  
Head of the Department  
Date: 23/8/25



**DR. C. A. SHEMBEKAR**  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST  
REG. No. 67862



Sign & Stamp  
Dean/ Principal/ Director of Training Centre  
Date: 23/8/25



**DR. C. A. SHEMBEKAR**  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST.  
REG. No. 67862

**Information of Mentor of Training Centre**  
It shall be verified by the Head of the concerned Training Center,

Sr. No.	Particular	Information to be filled
01.	Name of the Mentor	Dr. Chaitanya Shembekar
02.	Date of Birth	03-08-1969
03.	Address	21, Ramkrishna Nagar, Khamby Road, Nagpur
04.	Tel. No./ Mob. No.	9822 572744
05.	e-mail id	chaitanyashembekar@yahoo.com
06.	Nationality	Indian
07.	Qualification in details : (attach documentary proof)	MD (Obsty)
08.	Teaching Experience / Health Sciences: Profession Experience (Attached document proof with signature of Head of the Institute. Also it is mandatory to attach self-attested Photocopy of the Experience Certificate of each Mentor in the Subject of concerned Fellowship/Certificate Course)	Register → 1993-95 Asst. Prof → 1995-97 Guide → 2016-2025
09.	Present Appointment	Managing Director & Consultant
10.	Publications (List & Proof)	Attachee
11.	Post Graduate Teaching experience (Attach documentary evidence)	5 years
12.	Any other relevant information	—

Date: - 23/8/25

Name & Sign. of Mentor

**DR. C. A. SHEMBEKAR**

M. D

OBSTETRICIAN & GYNAECOLOGIST

REG. NO. 57862

For the use of affiliated Training Center:

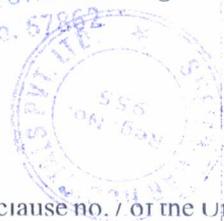
I have verified the eligibility of the above Mentor as per the criteria of eligibility prescribed by the University vide clause no.7 of the University Direction No. 05/2017 (Amended) and University Circular No. MUHS/UDC/FCCC/736/2019 dated 30/09/2019.

Sign & Stamp  
Head of the Department

Date: 23/8/25

DR. C. A. SHEMBEKAR  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST  
REG. No. 57862

Training Centre Round Seal



Sign & Stamp  
Dean/ Principal/ Director of Training Centre

Date: 23/8/25

DR. C. A. SHEMBEKAR  
M. D  
OBSTETRICIAN & GYNAECOLOGIST  
REG. No. 57862



**ANNEXURE – “G”**

**Information of Co-ordinator of Training Centre**  
It shall be verified by the Head of the concerned Training Center,

Sr. No.	Particular	Information to be filled
01.	Name of the Co-ordinator	Asmi chandorkar
02.	Date of Birth	15-01-1986
03.	Address	49, Vasant Nagar, Near Dekshabhoomi, Nagpur-470022
04.	Mob. No.	9881712354 8369263313
05.	E-mail id	asmi.omega@gmail.com
06.	Nationality	Indian
07.	Qualification in details (attach documentary proof)	M.S. (Counselling & Psychotherapy) MBA (HR & Marketing) M.A. (Economics)
08.	Present Appointment	HR & Administration, Incharge at Shembekar Hospital Nagpur
09.	Any other relevant information	—

Date: 23/8/2025

*Asmi*  
Sign. of Co-ordinator

Sign & Stamp  
Head of the Department  
Date: 23/8/25

  
**DR. C. A. SHEMBEKAR**  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST.  
REG. No. 67862

Sign & Stamp  
Dean/ Principal/ Director of Training Centre  
Date: 23/8/25

  
**DR. C. A. SHEMBEKAR**  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST  
REG. No. 67862



DECLARATION

I, the Dean / Director/ Principal of the Shembekar Hospital Pvt. Ltd  
Training Centre / Institute solemnly states on affirmation, that the information provided by me in  
Inspection Format as well as uploaded on Training Centre Website along-with all Annexures is  
true and correct to the best of my knowledge. The said information is provided to me by the  
concerned teachers and duly verified by me. It is further submitted the teacher's information attached  
in respective Annexure-E & F are not working in / at any other Training Centre /Institute or presented  
themselves at any inspection for the Academic Year 2024-2025 as per my knowledge and  
information provided by the concerned teachers. The teachers in the Annexure-E & F are staying  
in the same city / town / village where the Training Centre/ Institute is situated or adjacent to the  
city / town / village, where the Training Centre /Institute is situated and having the valid proof of  
residence of the said city / town / village. The teachers in the Annexure-E & F are not practicing in  
Training Centre working hours or out-side the City where the Training Centre /Institute is situated.

I am further hereby declare that every information or contents in this LIC Format is  
based on the information provided by the concerned teachers and endorsed by me after due  
verification and the same is/are absolutely true and correct. If at any stage it is revealed that any  
information or content given in this declaration is not true and correct, in such event the  
undersigned/ the concerned teacher as the case may be, shall be liable for disciplinary action or penal  
action or Affiliation of the Training Centre shall be withdrawal, as the case may be.

This declaration is voluntarily signed by me on 23 Day of ... 12/25 At... 6pm  
city / town / village, where the Training Centre /Institute is situated and having the valid proof of

Date: ..... 1 / ..... 2025  
Place: ... Nagpur

*Dr. C. A. Shembekar*  
Signature of Dean/Principal/Director  
Name of the Signatory  
(With Seal of the Training Centre)

**DR. C. A. SHEMBEKAR**  
M. D.  
OBSTETRICIAN & GYNAECOLOGIST  
REG. No. 67862

