

Application Form for “Recognition of Training Centre” by I.A.C.P.

Name of Centre: _____

Detail Postal Address: _____

State: _____ Pin: _____

Phone No.: _____ Email: _____

Contact Person and his/her details: _____

Whether affiliated to any University:

Whether it is an Institution/Hospital/Nursing Home/Therapy Centre/Child Development Centre or Centre run by voluntary NGO:

Government Institute /Private Institute/Trust:

Duration of establishment of Centre (in years):

Whether Centre head/ Contact person of centre is member of I.A.C.P.:

Whether Centre is well connected by Air/Trains to other cities:

Training offered in which sub specialty:

Surgery (Orthopaedic surgery, Neurosurgery):

Medicine (Developmental paediatrics, Paediatric Neurology, Psychiatry):

Therapy (Physiotherapy, Occupational therapy, Speech therapy, Special Education, Social worker, Psychology, Main stream education, Referral services resource Centre)

Duration of fellowship in weeks/months/year:

Nature of Accommodation available /facility you are going to offer:

Whether food facilities available:

How many Fellows/Trainees can be accommodated at one time?

Maximum stipend provided by institution per fellow per year as an endowment fund to I.A.C.P.:

Name of a person involved in Training/Trainer and qualification:

Any research papers publish by Trainer/Centre:

Any special experience in the field of Cerebral Palsy, Child hood disability, developmental disorders:

Whether centre will give multidisciplinary, interdisciplinary, transdisciplinary, mode of training:

Does Institution/Centre head/Trainer willing to accept terms and condition laid by I.A.C.P. executive council time to time:

I am binding to all rules and regulations laid by I.A.C.P. in breech of which recognition of my centre will be cancelled by executive council of I.A.C.P.

Signature of Institution Head/Contact person/Trainer