



FICCI Medical Value Travel Awards 2017
**Medical Value Travel Specialist Hospital
Application Form**

Eligibility Criteria:

- Any organization participating in the Awards should be an Indian entity with a registered presence in India.
- The Initiative/Service should be completely executed in the Indian operations of the participant organization
- Organization must have at least 2 years of registered presence and operations in India as on June 30, 2017
- The initiative / service should have been fully implemented on or after July 1, 2014
- The initiative / service should demonstrate an impact for the period July 1, 2016 to June 30, 2017
- Participating organizations must be engaged in providing health care services to the patients who are travelling from other countries to India for medical treatments.
- Employees and immediate family members of the award management, sponsors and partners of the awards are not allowed to participate in the Awards
- Participation in the awards is subject to defined rules and regulations available on website www.ahcindia.in

Instructions for completing this Application form

- Forms should be filled in English only.
- All mandatory questions (symbolised by *) must be answered. Incomplete forms or forms with incomplete sections may not be considered.
- Please maintain one copy of the completed form with you for your records
- Please provide up to 5 supporting documents wherever possible, to support your entry details. Supporting documents have to be in the following formats only – pdf, doc, jpeg etc. Size of each document cannot exceed 2 MB.
- Agreed Declaration by the Authorised person of the organisation is mandatory
- If you have any questions, or require any clarifications, please contact Mr Deepak Pawar on 9811098341 email at deepak.pawar@ficci.com or mvt@ficci.com ;

List of Documents

Mandatory Document (These documents are mandatory to provide. Unavailability of these documents may result in disqualification of the participant)

- Project launch date on company letter head

- **Additional Documents** (These documents are **not mandatory**; however, participants can provide them to support their application and claims)

Please note: Additional documents submitted should be relating to the project / initiative submitted for review. Any other document will be disqualified and will not be submitted to the Jury for review.

- Project report with budgets and approvals
- Reports to evidence measurable impact
- Current year Annual report
- Awards, certifications, accolades etc.
- Brochures, write ups, presentations, booklets, references
- Any other information you would like to highlight

SECTION 1 : PARTICIPANT INFORMATION

Name of participating entity *				
Name of Corporate or Group, Parent company or Trust <i>If part of a Corporate or Group or Parent company or Trust to which the participating entity belongs</i>				
Registered Entity Type	<input type="checkbox"/> Private <input type="checkbox"/> Public <input type="checkbox"/> Other (Please Mention) _____			
Number of centres / branches / offices				
Website URL*				
Number of city(s) / countries with presence *				
Contact person *	Name: Email: Contact:			
Address of registered office in India *				
Year of incorporation (in dd/mm/yyyy) *				
Revenue (Rs. in crores) *	<input type="checkbox"/> Less than 25	<input type="checkbox"/> 26 - 100	<input type="checkbox"/> 101 -250	<input type="checkbox"/> More than 250
<p><u>Please select category</u></p> <p><input type="checkbox"/> Cardiology (Interventional cardiology)</p> <p><input type="checkbox"/> Cardiology (Cardiac Surgery)</p> <p><input type="checkbox"/> Paediatric Cardiac Sciences (Cardiology and Cardiac Surgery)</p> <p><input type="checkbox"/> Oncology</p> <p><input type="checkbox"/> Neurosciences</p> <p><input type="checkbox"/> In Vitro Fertilization / Infertility</p> <p><input type="checkbox"/> Transplant – Liver</p> <p><input type="checkbox"/> Transplant - Kidney</p> <p><input type="checkbox"/> Transplant - Heart</p> <p><input type="checkbox"/> Transplant - Bone Marrow</p> <p><input type="checkbox"/> Spine Surgery</p> <p><input type="checkbox"/> Orthopedics (Joint Replacement)</p>				

SECTION 2 : CASE STUDY

I. Initiative /Service *

a) Summarise the Facility and services provided by the organization for the international patients (Max 500 words)

: The details provided should only be for patients travelling from abroad. The list of details should include

- *Specific to the category selected, please explain the treatments provided to international patients*
- *Kinds of Technology used to provide the treatment*
- *How is your organization reaching out to the international patients to promote the treatments provided*
- *Ease of process to come for the treatment*
- *Total number of beds occupied by international patients*
- *Specialized treatment provided to patients*
- *What is unique about the treatments provided by you Etc.)*
- *Any other information*

II. IMPACT

II. Impact of the Initiative/service details provided during the period between July 1, 2016 to June 30, 2017

Below listed are few success criteria that indicate the objectives have been met and the benefits delivered ONLY for patients travelling from countries apart from India

Project should be measurable and generic statements should be avoided

Change in percentage / absolute numbers YoY / MoM must be mentioned in the table provided for each success criteria

1. BUSINESS

Please explain how your initiative/service has impacted your business.(max 100 words)

Parameters	2014 - 2015	2015 - 2016	2016 - 2017
Increase in turnover of the organization			
Number of tie ups with domestic hospitals			
Number of tie ups with international hospitals			

2. OPERATIONS

Please explain how your initiative/service has impacted your operations.(max 100 words)

Parameters	2014 - 2015	2015 - 2016	2016 - 2017
Amount of reduction in maintenance cost			
Turnaround time of patient treatment			
Reduction in downtime			

3. EMPLOYEES

Please explain how your initiative/service has impacted your employees.(max 100 words)

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Parameters	2014 - 2015	2015 - 2016	2016 - 2017
Hours of training provided internally to staff to deal with international patients			
Number of translators in house to help with the process			
Number of doctors especially to provide treatment to international patients			

4. PATIENTS

Please explain how your initiative/service has impacted your patients.(max 100 words)

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Parameters	2014 - 2015	2015 - 2016	2016 - 2017
Number of number of international patients			
Number of countries operating in from where patients are brought to India			
Number increase in patient traffic from untapped markets			

5. Additional Information

Please explain how your initiative/service has impacted your any other success criteria.(max 100 words)

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Please describe the details of kinds of services provided to international patients post treatment (max 300 words)

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III. Sustainability for the Initiative/Service

a) Please describe the key developments from your end to ensure the sustainability of the initiative/service in the next 2 years (max 200 words)

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b) Why should your organization win this award (max 75 word) *

IV. ACCREDITATIONS

Accreditation	Year of Accreditation / Empanelment	Number of non-compliances review by the accreditation committees in the last one year
JCI		
NABH		
ISO		
Others		

Details of any other awards or certification(s) obtained by the organization (Please provide supporting documents)

PARTICIPANT DECLARATION

I declare that the information provided in this entry form is correct and accurate to the best of my knowledge. I agree to abide by the rules and regulations of participation. I /We agree, on behalf of my/ our Organization authorise the award management to use the content submitted as part of my/our entry, in whole or in part and use and display such entry, which shall include trade publications, press releases, electronic posting to the Awards website, electronic hyperlinks to the website of the Participant, and any display format selected by the award management during the awards ceremony or at a later point in time, for a period of five years.

Participant's name: _____

Signature: _____

Designation: _____

Date: _____

* The Application Form needs to be signed by the authorized signatory from the participant organization (Senior Management)