NORTH EAST CHRISTIAN UNIVERSITY

Govt. of Nagaland. Act Gazette No. LAW/NECU-10/2012 (Act No. 4 of 2013)
Anchor Complex, Burma Camp East Block, Post Box-109
Dimapur-797112, Email: necuvarsity@gmail.com Website – www.necu.ac.in

PASTE PASSPORT PHOTO

QCI PrCB 002

Application No.:_____

Application Form for Voluntary Certification Scheme for Traditional Community Healthcare Providers (VCSTCHPs)

1. Full Name:

2. Sex: Male / Female_____ 3. **Date of Birth:** (dd/mm/yyyy)

Contact Address: _____

_____

Taluka: _____ **District:** _____ **Pin Code:**

Telephone No. **Mobile No:**

Fill in the particulars of family elder / Guru who trained the applicant in folk treatment for primary healthcare related common ailments:

Full Name: _____**Relationship:**_____

Contact Address:_____

Taluka:_____ **District:** _____ **Pin Code:**

Telephone No. **Mobile No:**

Your years of experience or practice as TCHP: _____ years

Are you employed or were employed of NECU? YES/NO If Yes, Year_____ Designation_____

LIST THE STREAMS OF PRACTICE:

Which stream(s) would you like to be assessed for certification? Please Tick (✔) any 'ONE Domain'

- ☐ Common Ailments
- ☐ Poisonous Bites
- ☐ Traditional Bone Setting
- ☐ Jaundice
- ☐ Traditional Birth Attendant
- ☐ Arthritis

Have you registered with any PrCB before? Yes/ No _____

Was your application rejected before? Yes/ No _____

If already certified or applied assessment under the same scheme, state your application number?
Any Special Need? _____

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DECLARATION

I hereby declare that to the best of my knowledge and ability I provide traditional/folk treatment for primary healthcare conditions with herbal remedies and as trained by my family elder / Guru mentioned above and that I Do Not provide any treatment to my patients with help of medicines of Allopathy or Homoeopathy. I hereby declare that all information provided by me above are truthful and to the best of my knowledge.
I have enclosed self-attested 3 passport size photographs

(_____)
Applicant's Signature

Name: _____

Date: _____ (dd/mm/yyyy)

Place: _____

APPLICATION FEES PAYMENT STATUS: (₹7500 per domain)

1. **Mode of Payment**: Cash/ Draft/ Account Transfer
   Transaction ID: ……
2. **Amount Received (✔) : Yes/ No Date:** …….. (DD/MM/YY)

FOR OFFICE USE ONLY

Application Status: Selected/ Rejected

Reason(s)

_____
_____
_____
_____
_____

Signature: _____

(Technical Head/ Quality Manager)

Date: _____(dd/mm/yyyy)
Place: _____

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CODE OF CONDUCT for TCHPs

The Scheme for Voluntary Certification of Traditional Community Healthcare Providers (TCHP) recognizes the importance of the role played by the TCHP in primary healthcare (http://www.qcin.org/Traditional-Community-Healthcare_Providers.php). Consequently, it is the responsibility of the TCHP to ensure a responsible, safe and protected environment towards those who seek care.

In order to uphold the highest work standards for TCHPs, I accept the following foundational principles:

1. I shall avoid discriminating against or refuse to provide care to anyone who seeks it from me, based on race, gender, sexual orientation, religious, or national origin.
2. I shall expand my knowledge and skills in the stream of healthcare services through peer-meetings, educational activity and study.
3. I shall maintain an ethical and moral practice in the stream of healthcare service certified for and shall not misrepresent my certification.
4. I shall follow a healthy lifestyle.
5. I shall establish and maintain safe work environment and working relationship with all healthcare seekers.
6. I shall cultivate an attitude of humanity in my work and support community health initiatives.
7. I shall only handle cases in my stream of healthcare service and refer any emergencies to the nearest health facility.
8. In all Traditional healthcare related matters, I shall maintain best practices and procedures and strive to continuously enhance knowledge and skills.
9. I view my knowledge, services and work associations as being transparent and for the benefit of the people in my community.
10. I shall respect the integrity and protect the welfare of all persons who seek healthcare from me and recognize that it is our obligation to safeguard any information about them obtained in the course of service provision.
11. I shall not carry out any advertisements, including any announcement, public statement or promotional material made by me, or for me, for informing the public about our activities.
12. I shall not make public statements, advertisements, etc. which are false, fraudulent, misleading or deceptive.
13. I shall display my certificate (both sides) visibly at my workplace. I shall not misuse the certificate issued in any way that goes against the norms specified by PrCB/ Scheme owners from time to time.
14. I shall comply with all requirements as in and when prescribed, conforming to relevant accreditation standards (ISO 17024) and the Scheme document laid by QCI from time to time.

Name of TCHP: _____

Signature/ Thump impression of TCHP: _____

Application Number: _____

Date: _____ (dd/mm/yyyy**)** **Place:** _____

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SELF DECLARATION

I, (Name of the TCHP) _____, confirm that I provide traditional healthcare to my community in the stream of _____ in accordance to knowledge and skills acquired from my family/Guru. I understand that if I am found to be claiming to provide my services of any formal system of medicine or misrepresenting my certification, at a later date, my certification maybe suspended and / or withdrawn.

I also confirm that I am in good health and of sound mind to be able to impart healthcare services and will bring it to your notice when there is a change in my health which will adversely affect my functioning as a traditional community healthcare provider (TCHP). I understand that if I am found not fit health-wise to discharge my duties as a TCHP at a later date, my certification can be suspended and / or withdrawn.

I will ensure a safe and responsible environment in my workplace and provide quality care to all those who seek it from me.

I confirm that I have read and/ or understood the document forming part of this declaration.

Special Needs: I have _____ disability and would need special assistance complete the evaluation process.

Name of TCHP: _____

Signature/ Thump impression of TCHP: _____

Application Number: _____

Date: _____ (dd/mm/yyyy)

Place: _____

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FREE PRIOR INFORMED CONSENT FORM FOR APPLICANT TCHPs

Part 1: Information Sheet

This assessment of your knowledge and skill-based competency is being carried out under the Quality Council of India (QCI)–Foundation for Revitalization of Local Health Traditions (FRLHT) Voluntary Certification Scheme for Traditional Community Health Providers (VCSTCHP) (http://www.qcin.org/Traditional-Community-Healthcare-Providers.php). The assessment would be carried out by means of oral evaluation, case presentation, practical demonstration and field verification. Information with regard to your practice and the medicines, procedures and techniques that you employ for the same may be disclosed during the course of your assessment. As per the commitments and obligations under national laws, the information disclosed shall be treated as confidential. The information collected is only for the purpose of assessing knowledge and certification. Your participation in this assessment is voluntary and you have every right to withdraw from the assessment without assigning any reason whatsoever.

On successful completion of the assessment of your knowledge and skill, you will be certified for the specific stream of healthcare service for which you were assessed. The Certificate would have the validity for a period of 5 years. If you feel you were benefitted by the certificate you may apply for recertification and would have to undertake the process of assessment of your knowledge and skills.

The Certificate would not allow you for the claim of any sort of registration as a medical practitioner or inclusion in the mainstream medical system.

Part 2: Voluntary consent of applicant TCHP

I (Applicant TCHP name) have read/ been informed of the above and given opportunity to clarify any queries to my satisfaction. I consent to share information as required for my assessment.

Name of TCHP: _____

Signature/ Thump impression of TCHP: _____

Application Number: _____

Date: _____ (dd/mm/yyyy)

Place: _____

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Endorsement by Village Panchayath Gram Sabha / Grama Panchayath

(Please confirm (a) Identity, (b) Residential Address, (c) Number of years practicing, (d) Streams of Practice and (e) Usefulness of the TCHP in your village community)

We hereby state that Shri/Smt. _____ son/daughter/ husband/wife of Shri/Smt. _____ is practicing as a TCHP in the _____ Village,_____ Post, _____Taluka, _____District, _____State since_____ years. We also state that s/he is providing traditional community healthcare for the following streams of practice as mentioned below (please specify).

_____

We endorse that the services of Shri / Smt._____ as a TCHP has been very beneficial to our village community.

We declare that Shri / Smt._____ has no pending criminal case against him/her.

Name: _____

Signature and Seal: _____

Date: _____(dd/mm/yyyy)

Place: _____

(This document to be obtained from the Grama Sabha / Grama Panchayath President or Secretary of the place of residence of the TCHP)

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