FICCI Medical Value Travel Awards 2019

Ayurveda

Application Form

Eligibility Criteria:

- Any organization participating in the Awards should be an Indian entity with a registered presence in India.
- **Any organization participating should be NABH Accredited**
- The 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, 2019
- The service should have been fully implemented on or after July 1, 2016
- The service should demonstrate an impact for the period July 1, 2018 to June 30, 2019
- Participating organizations must be engaged in providing Ayurvedic 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.xxxxx.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 Ms. Aparna Sharma on 8448344468 email at aparna.sharma@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
- Date of Incorporation on company letter head
- NABH Accreditation Certificate

- **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 service 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 *	
Address of participating entity *	
NABH Accreditation Certificate Number*	
Year of incorporation (in dd/mm/yyyy) of the participating entry*	
Revenue (Rs. in crores) of the participating entry *	☐Less than 25 ☐26 – 100 ☐ 101 -250 ☐More than 250
Name of Corporate or Group, Parent company or Trust *If part of a Corporate or Group or Parent company or Trust to which the participating entity belongs*	
Registered Entity Type	☐ Private ☐ Public ☐ Other (Please Mention) ________________________________
Number of centres / branches / offices	
Website URL*	
Number of city(s) / countries with presence *(Please provide the details)	
Contact person *	Name: Email: Contact:

SECTION 2 : CASE STUDY
I. The service*
a) Summarise the services provided by the organization for international patients (Max 500 words) *: The details provided should be only for the* ***participating entity and ONLY patients travelling from abroad****. The list of details should include* - *Treatments provided at centre for international patients* - *Methodology used to provide the treatment* - *Ways you organization reaching out to the international patients to promote the treatments provided* - *Types of skilled staff at the centres to assist with the treatments provided* - *Ease of process to visit the centres for international patients* - *Unique about the treatments provided by you. Kindly provide the sample of case study* - *Any other information*

II. IMPACT

Impact of the services details provided during the period between July 1, 2018 to June 30 , 2019

Below listed are few success criteria that indicate the objectives have been met and the benefits delivered ***ONLY for participating entity and 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 services have impacted your business.(max 100 words)

Parameters	2016 – 2017	2017 – 2018	2018 – 2019
Total Medical Value Tourism Business turnover (In Rs.)			
% of Medical Value Tourism Turnover w.r.t total turnover for the hospital			
Number of International Hospital Tie ups for Medical Value Tourism			
Number of Countries associated for Medical Value Tourism			
Market share growth			
Number of unique services provided (please provide brief descriptions)			
Any others			

2. OPERATIONS

Please explain how your services has impacted your operations.(max 100 words)

Parameters	2016 - 2017	2017 - 2018	2018 - 2019
Marketing spends (in INR)			
Turnaround time of patient treatment			
Any others			

3. EMPLOYEES

Please explain how your services has impacted your employees.(max 100 words)

Parameters	2016 - 2017	2017 - 2018	2018 - 2019
Number of skilled employees (full time)			
Hours of mandatory training for employees (please briefly describe the training provided)			
Any others			

4. PATIENTS

Please explain how your services have impacted your patients.(max 100 words)			
Parameters	**2016 - 2017**	**2017 - 2018**	**2018 - 2019**
Number of international patients visiting for treatment			
Number of countries patients visiting from (please provide details)			
Any others			
5. Any additional information			
Please explain how your services have impacted your any other success criteria.(max 100 words)			

Please describe the details of services provided to the international patients for any post treatment care (max 300 words)
III. Sustainability for the Project/initiative/innovation/service
Sustainability for the services. Should be ONLY for participating entity, speciality selected and patients travelling from countries apart from India
a) Please describe the key developments from your end to ensure the sustainability of the services in the next 2 years (max 200 words)
b) Why should your organization win this award (max 75 word)

IV. Patient Feedback for the Project/initiative/innovation/service
Patient Feedback for the services should be ONLY for participating entity, speciality selected and patients travelling from countries apart from India
Please provide minimum 5 patient feedbacks for the services (max 200 words)

V. ACCREDITATIONS (Please specify and provide details)		
Accreditation/Certification types	**Year of Accreditation/certification**	**Number of non-compliances review by the accreditation committees in the last one year**
NABH *		
Details of any other awards or certification(s) obtained by the organization for medical value travel (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)*