

FICCI Medical Value Travel Awards 2019  
**Medical Facilitator  
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 services 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 services should have been fully implemented on or after July 1, 2016
- The services should demonstrate an impact for the period July 1, 2018 to June 30, 2019
- 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.xxxxx.in](http://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](mailto: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 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 *   |  |
| 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 *   | <input type="checkbox"/> Less than 25 <input type="checkbox"/> 26 – 100 <input type="checkbox"/> 101 -250 <input type="checkbox"/> More than 250 |
| Name of Corporate or Group, Parent company or Trust<br><br><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 Limited<br><input type="checkbox"/> Other (Please Mention) _____  |
| Number of centres / branches / offices   |  |
| Website URL*   |  |
| Number of city(s) / countries with presence *(Please provide the details)  |  |
| Contact person *   | Name:<br>Email:<br>Contact:  |

**SECTION 2 : CASE STUDY****I. The services\***

a) Summarize the services provided by your organization for the international patients (Max 500 words)

*: The details provided should be only for the **participating entity and ONLY patients travelling from abroad***

- *Global tie ups with hospitals and doctors*
- *Local tie up with hospital and doctors*
- *Ways your organization reaches out to the international patients to promote the treatments provided in India*
- *Types of assistance they provide (visa process, stay details, family travels, translators etc)*
- *Any other information*

**II. IMPACT**

**II. 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 |
|--|-------------|-------------|-------------|
| Organization turnover  |             |             |             |
| Number of tie ups with domestic hospitals (please provide details names of organizations, type of tie – up, others)      |             |             |             |
| Number of tie ups with international hospitals (please provide details names of organizations, type of tie – up, others) |             |             |             |
| Any others (please specify)  |             |             |             |

**2. OPERATIONS**

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

| Parameters | 2016 – 2017 | 2017 - 2018 | 2018 - 2019 |
|------------|-------------|-------------|-------------|
|------------|-------------|-------------|-------------|

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|---|--|--|--|
|   |  |  |  |
| Marketing, promotions spending for brand visibility   |  |  |  |
| No. of international enquiries received in the selected speciality (please provide details to support the same) |  |  |  |
| No. of enquiries converted (please provide details to support the same)   |  |  |  |
| Conversion Rate (%)   |  |  |  |
| Any others (please specify)   |  |  |  |

### 3. EMPLOYEES

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

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| Parameters  | 2016 – 2017 | 2017 - 2018 | 2018 - 2019 |
|---|-------------|-------------|-------------|
| Number of employees (full time) (please provide details of types, qualifications, others) |             |             |             |
| Hours of training provided to full time employees   |             |             |             |
| Types of training provided to employees   |             |             |             |
| Any others  |             |             |             |

### 4. PATIENTS

Please explain how your services have impacted your patients.(max 100 words)

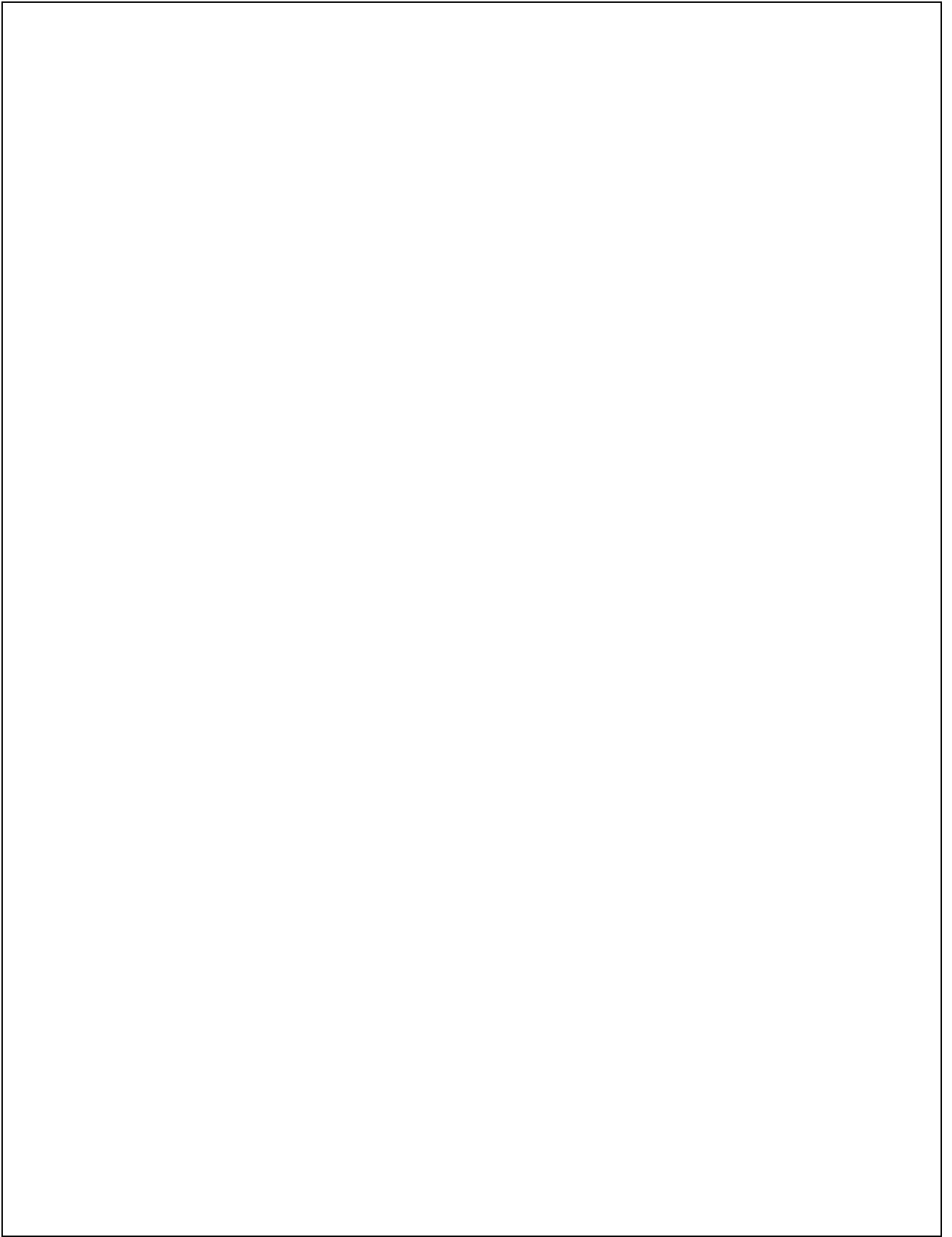
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| Parameters  | 2016 – 2017 | 2017 - 2018 | 2018 - 2019 |
|---|-------------|-------------|-------------|
| Number of international patient bought to India (please provide details with supporting such as from which countries, types of treatments provided, others) |             |             |             |
| Reach in Countries (please provide name and number)   |             |             |             |
| Language Interpreters employed full-time (please provide details of the numbers, languages spoken, etc)   |             |             |             |
| Language Interpreters employed part-time time (please provide details of the numbers, languages spoken, etc)  |             |             |             |
| 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 the kinds of services provided to international patients for post treatment care (max 300 words)

**III. Sustainability for the services**

**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 services**

**Patient Feedback for the services. Should be ONLY for participating entity and patients travelling from countries apart from India**

Please provide minimum 5 patient feedbacks for the services (max 200 words)

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**V. ACCREDITATIONS**

| <b>Accreditation</b> | <b>Year of Accreditation /<br/>Empanelment</b> | <b>Number of non-compliances review by the accreditation<br/>committees in the last one year</b> |
|----------------------|--|--|
| NABH *               |  |  |
| ISO                  |  |  |
| MTA                  |  |  |
| MTDA                 |  |  |
| Others               |  |  |

Details of any other awards or certification(s) obtained by the organization for the services you provide to international patients (Please provide supporting documents)

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## 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)*