



BCP-I RECERTIFICATION: FORM -1: PERSONAL DETAILS

BCP-I Certificate No. _____ **Recertification Period: Jan 20** _____ **to Dec 20** _____

BEFORE YOU FILL THIS FORM, KINDLY READ THE RE-CERTIFICATION GUIDELINES

NOTE: FORM 1 IS COMMON FOR ALL RECERTIFICATION YEARS

PLEASE USE CAPITAL LETTERS ONLY OR TYPE THE DETAILS

Name as per BCP-I certificate: _____

Residential address: _____

City: _____ State: _____ PINCODE: _____

Country: _____ Mobile: _____

E-mail: _____

Employers address:

Hospital: _____

Address: _____

City: _____ State: _____ PINCODE: _____

Country: _____

Your Current Designation : _____

Signature of Perfusionist: _____ Place: _____ Date _____

PLEASE SEND MY CERTIFICATE TO RESIDENTIAL ADDRESS () HOSPITAL ADDRESS ()

CONDITIONS OF EMPLOYMENT: (YOU MUST BE CURRENTLY EMPLOYED AS A PERFUSIONIST)

Have you been continuously employed in the last Five years: YES / NO

(if "NO", please specify period(s) of break(s) & explain on reverse side)

(start with latest)

MM/YYYY

MM/YYYY

1) Name of Employer: _____ From: _____ To _____

2) Name of Employer: _____ From: _____ To _____

3) Name of Employer: _____ From: _____ To _____

4) Name of Employer: _____ From: _____ To _____

5) Name of Employer: _____ From: _____ To _____

Signature and stamp of HOD / HR Name: _____

Designation: _____ Signature: _____

Dept Seal: _____



BCP-I RECERTIFICATION FORM - 2: CLINICAL ACTIVITY				
BCP-I Certificate No. _____		Recertification Year: Jan 20____ to Dec 20____		
No.	Date	Procedure	Self / Under supervision	Points
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
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40				

NOTE: IF YOU NEED MORE SHEETS, PLEASE TAKE ADDITIONAL PRINT OF THIS PAGE
FILL OUT A SEPARATE FORM FOR EACH RECERTIFICATION YEAR.



BCP-I RECERTIFICATION FORM - 3A: PROFESSIONAL ACTIVITY

Conference / Seminar/ Refresher Course/ In-house Training

BCP-I Certificate No. _____ Recertification Year: Jan 20____ to Dec 20____

Date (s): _____ Location: _____

Name of the Conference / Seminar / Course

Organizing Institution:

Name of HOD / ORGANISER: **(ONLY FOR IN-HOUSE TRAINING)**

Designation:

Signature:

Dept Seal:

Date (s): _____ Location: _____

Name of the Conference / Seminar / Course

Organizing Institution:

Name of HOD / ORGANISER: **(ONLY FOR IN-HOUSE TRAINING)**

Designation:

Signature:

Dept Seal:

Date (s): _____ Location: _____

Name of the Conference / Seminar / Course

Organizing Institution:

Name of HOD / ORGANISER: **(ONLY FOR IN-HOUSE TRAINING)**

Designation:

Signature:

Dept Seal:

Date (s): _____ Location: _____

Name of the Conference / Seminar / Course

Organizing Institution:

Name of HOD / ORGANISER: **(ONLY FOR IN-HOUSE TRAINING)**

Designation:

Signature:

Dept Seal:

PLEASE FILL OUT A SEPARATE FORM FOR EACH OF THE 2 RECERTIFICATION YEARS. COPY OF ATTENDANCE CERTIFICATE IS A MUST. SIGN OF **HOD IS TO BE TAKEN **ONLY** FOR **IN-HOUSE TRAINING**, IF THERE IS **NO** SEPARATE ATTENDANCE CERTIFICATE**



BCP-I RECERTIFICATION FORM- 3B: PROFESSIONAL ACTIVITY
Oral Presentations, Posters and Written Publications

BCP-I Certificate No. _____ Recertification Year: Jan 20____ to Dec 20____

Journal title, date, volume, page of publication / OR Title of Oral Presentation / Poster with name of meeting, place and date of presentation:

Journal title, date, volume, page of publication / OR Title of Oral Presentation / Poster with name of meeting, place and date of presentation:

Journal title, date, volume, page of publication / OR Title of Oral Presentation / Poster with name of meeting, place and date of presentation:

Journal title, date, volume, page of publication / OR Title of Oral Presentation / Poster with name of meeting, place and date of presentation:

PLEASE FILL OUT A SEPARATE FORM FOR EACH OF THE 2 RE-CERTIFICATION YEARS
FOR PUBLICATIONS: PLEASE ATTACH A COPY OF PUBLISHED ABSTRACT OR
ARTICLE AS IT APPEARED

FOR PRESENTATIONS: PLEASE ATTACH ATTENDANCE CERTIFICATE WHICH
SHOULD SPECIFY THAT A PRESENTATION WAS MADE / POSTER WAS DISPLAYED



BCP-I RECERTIFICATION FORM -4: SUMMARY OF POINTS EARNED						
BCP-I Certificate No. _____		Recertification Period: Jan 20 _____ to Dec 20 _____				
CLINICAL ACTIVITY:	YEAR	1st 20	2nd 20	3rd 20	4th 20	5th 20
ECC IN CARDIAC SURGERY (PRIMARY) (1 point /case)						
SUPERVISED ECC (1 point /case)						
ECC AS INSTRUCTOR (1 point /case)						
ECC FOR OTHER SURGERIES (1 point /case)						
ECMO/VAD (one point/case/Perfusionist involved)						
ECC in research (½ point /case)						
STANDBY FOR OPCAB (½ point /case) (MAX 10 points / year)						
Total Clinical Activity Points (MIN 40 points / YEAR)						
PLEASE FILL OUT THE TOTAL POINTS FOR EACH YEAR						
PROFESSIONAL ACTIVITY:						
PASSIVE ATTENDANCE						
a. IN HOUSE CONFERENCE, SEMINAR, WORKSHOP (5 points)						
b. NATIONAL CONFERENCE, SEMINAR, WORKSHOP (15points)						
c. INTERNATIONAL CONFERENCE, SEMINAR, WORKSHOP (20 points)						
ACTIVE ATTENDANCE						
d. PRESENTATION AT IN-HOUSE SEMINAR, OR WORKSHOP (2 points)						
e. PRESENTATION AT NATIONAL SEMINAR, OR WORKSHOP (3 points)						
f. MODERATOR AT NATIONAL CONFERENCE (3 points)						
g. PRESENTATION AT INTERNATIONAL SEMINAR OR WORKSHOP (5 points)						
h. MODERATOR AT INTERNATIONAL CONFERENCE (5 points)						
PUBLICATIONS						
i. PUBLISHED ABSTRACTS (1 point)						
j. JOURNAL WITHOUT EDITORIAL POLICY (4 points)						
k. JOURNAL WITH EDITORIAL POLICY (8 points)						
l. AUTHOR OF CHAPTER IN PERFUSION RELATED BOOK (15 points)						
Total Professional Activity Points (min. 20 pts/year)						
(any 2 out of 5 year period)						
PLEASE FILL OUT THE TOTAL POINTS FOR EACH YEAR						



Form 5: VERIFICATION AND FEES DETAILS:

I certify that the above information is true to the best of my knowledge and belief:

BCP-I Certificate No: _____

Name of the Perfusionist: _____
(FULL NAME AS IT APPEARS IN YOUR CURRENT CERTIFICATE - IN CAPITAL LETTERS)

Signature: _____ Date: _____

Name of Chief Perfusionist:

(FULL NAME IN CAPITAL LETTERS) (NOTE: IF YOU ARE THE SENIORMOST, PLEASE WRITE SELF)

Signature: _____ Date: _____

Name of Chief Surgeon / HOD C.V.T.S.:

(FULL NAME IN CAPITAL LETTERS)

Signature: _____ Date: _____ SEAL OF SURGEON

DETAILS OF FEES: Please refer to the guidelines for details and how to pay the fees. Fill out the transaction details below and also send a copy of the transaction receipt

Transaction No. _____ DATED _____

FROM (NAME, BRANCH & CITY OF ISSUING BANK)

AMOUNT: Rs. 1500 / 3000

NOTE: PLEASE SEND YOUR COMPLETED APPLICATION FORM WITH ALL RELEVANT DOCUMENTS VIA EMAIL TO: recertify.bcp@gmail.com

LOKNATH TIWARI
SECRETARY, BCP-I
Cell: +91-9831497490
Email: recertify.bcp@gmail.com;

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