TDU
THE UNIVERSITY OF TRANS-DISCIPLINARY HEALTH SCIENCES & TECHNOLOGY

Voluntary Certification Scheme for Traditional Community Healthcare Providers (VCSTCHPs)

1) **Full name**:

1.1) **Sex:** Male / Female 1.2) **Date of Birth**:

1.3) **Contact Address:**

1.4) **Block/Taluka**: 1.5) **District**: 1.6) **Pin code:**

1.7) **Telephone Number:** 1.8) **Mobile Number:**

2) **Particulars of family elders/ Guru who trained the applicant:**

2.1) **Full name**: 2.2) **Relationship**:

2.3) **Contact Address:**

2.4) **Block/Taluka**: 2.5) **District**: 2.6) **Pin code:**

2.7) **Telephone Number:** 2.8) **Mobile Number:**

3) **Applicants years of experience or practice as TCHP: Years**

4) **Which stream(s) would you like to be assessed for certification?**

☐ *Common Ailments* ☐ *Traditional Birth Attendant*

☐ *Jaundice* ☐ *Traditional Bone Setting*

☐ *Poisonous Bites* ☐ *Joint Pain*

5) **List the other streams in which you practice: i) ii) iii)**

6) **Preferred language for assessment:**

7) **Have you registered with any PrCB before?** ☐ Yes ☐ No

8) **Was your application rejected before?** ☐ Yes ☐ No

9) **If already certified or applied assessment under the same scheme, state your application number?**

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 **2 passport size photographs**.

Date: **Signature/Thumb impression of applicant**
Place:

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Endorsement by Village Panchayath Gram Sabha / Grama Panchayat / Local Government

(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 here by state that Shri/Smt__________________________________

Son/Daughter/Husband /Wife of Shri/Smt__________________________is practicing as a

TCHP in the Village,____________________Post,__________________District_____________

State_________________, for________years.

We also state that she/he is providing traditional community healthcare for the following streams of practice as mentioned below (please tick whichever is applicable):

- ☐ *Common Ailments*
- ☐ *Jaundice*
- ☐ *Poisonous Bites*
- ☐ *Traditional Birth Attendant*
- ☐ *Traditional Bone Setting*
- ☐ *Joint Pain*

We endorse the services of Shri/Smt.______________________________as a Traditional Community Healthcare Provider (TCHP) have been very beneficial to our village community.

Date:

Place:

Sign: __________________

Name: __________________

Seal:

(This document is to be obtained from the Grama Sabha / Grama Panchayat/Local Government President or Secretary of the place of residence of the TCHP)

THE UNIVERSITY OF TRANS-DISCIPLINARY HEALTH SCIENCES & TECHNOLOGY

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. Consequently, it is the responsibility of the TCHP to ensure a responsible, safe and protected environment towards those who seek care from him/her.

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 practice through peer-meetings, educational activity and study.
3. I shall maintain an ethical and moral practice in the stream of practice 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 care 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 practice 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 care 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 work place.

Name of TCHP: Date:

Signature of TCHP: Place:

SELF DECLARATION

I, (Name of the TCHP)___________________________confirm that I provide traditional healthcare to my community in the stream of in accordance with 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 do not have any judicial proceedings pending w.r.t. my conduct or any pending proceedings in any regulatory body. I confirm that on no instance any discomfort or disability has been caused by me to any of my patients in the course my treatment, in the past two years.

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.

Signature of the Applicant

Application number:

Date:

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FREE PRIOR INFORMED CONSENT

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.

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,_____________________________________have read/ been informed of the above and given the opportunity to clarify any queries to my satisfaction. I consent to share information as required for my assessment.

Name of TCHP ________________________

Signature of applicant TCHP or Thumb impression of applicant TCHP

Date:
Place: