ANNEXURE – II

FORM I.

(see rule 7(1))

APPLICATION FORM FOR REGISTRATION / RENEWAL OF REGISTRATION OF CLINICAL ESTABLISHMENT

ESTABLISHMENT DETAILS

1 Name of the Clinical Establishment: 1. Registration No:

2. Address:

Village/Town: Taluk

District: State: Pincode

Telephone No.(with STD code) Mobile: Fax: Email ID: Website (if any)

3. Year of starting:

(From 4 to 11, Mark all whichever is applicable)

4. Location:

Metro State Capital City Town

Notified Area Village Any other (Please specify):

5. Ownership of Services.-

Public Sector

Central Government	State Government	Local Government (please specify)
Public Sector Undertaking	Railways	Employees State Insurance Corporation
Autonomous organization	Society/Not for profit Companies	Any other (please specify)

Private Sector

Individual Proprietorship	Registered Partnership	Registered Company
Corporation (including a society) registered under a Central, Provincial or State Act (Please specify)		
Trust (including Charitable) registered under a Central, Provincial or State Act (please specify)		
Branch of a Foreign Service provider (please specify)		
Any other (please specify)		

6. Name of the owner of Clinical Establishment:

Address:

Village/Town: Taluk

District: State: Pincode

Telephone No.(with STD code) Mobile: Fax:

Email ID:

7. Name, Designation and Qualification of person-in-charge of the clinical establishment

Designation: Qualification:

Address:

Village/Town: Taluk

District: State: Pincode

Telephone No.(with STD code) Mobile: Fax:

Email ID:

8. Any other (please specify)

9. Type of clinical establishment :(Please tick whichever is applicable)

Clinic

Single Practitioner	Consulting Room	Polyclinic
	Dental	
Any other (Please specify)		

Centre

Primary Health Centre	Community Health Centre	Urban Health Centre
Dispensary	Day Care Centre	Counselling centre
Physiotherapy Centre	Yoga Centre	In Vitro Fertilization (IVF) Centre
Dialysis	Hospice Centre	Any other (like Audiometry, Prosthetic & orthotic etc., (please specify)

Hospital

General Practice Services	Maternity Home
Single speciality Services	Multi Speciality Services
Super speciality Services	Operation Theatre
Emergency Causality	Intensive Care Unit
ICCU	Any other please specify

10. Whether the clinical establishment,-

(a) is attached with Laboratory (if so, please tick whichever is applicable)

Pathology	Haematology	Histopathology
Cytology	Genetics	Samples Collection Centre
Any other (Please specify)		
Biochemistry	Microbiology	Any other (please specify)

If answer to (a) above is yes, the following details may be furnished, namely:-

-- Tests that it proposes to carry out

-- List of equipments available

-- A list of technical staff (both technical and supervisory)

-- List of personnel who are going to sign test reports.

(b) is attached with Imaging Centre (if so, please tick whichever is applicable)

Portable X ray	Conventional X Ray	Digital X Ray
X Ray with computed Radiography system	Ultrasound	Ultra sound with Color Doppler
Mammography	Orthopentogram(OPG)	CT Scan
Magnetic Resonance Imaging (MRI)	Positron Emission Tomography (PET) Scan	Bone Densitometry
Uro -flowmetry	Any other (Please specify)	

(c) is attached with Blood Banks (if so, please tick whichever is applicable)

(A) Based on Location		
Stand alone	Hospital Based	Any other (please specify)

(B) Based on Facilities

Blood bank/Centre having whole blood facility only
Blood bank/Centre having whole blood and component facility
Blood bank/Centre having whole blood and/or component facility with any other additional facility (please specify):

11. Details of the equipments maintained with :-

SYSTEM OF MEDICINE

12. Services offered (please tick whichever is applicable)

(a) Allopathic

Speciality

Medical	Surgical	Obstetrics and Gynecology	Paediatrics
Any other please specify			

(b) Ayurveda

Anusadh Chikitsa	Shalya Chikitsa	Shodhan Chikitsa	Rasayana
Pathya Vyavastha	Any other please specify		

(c) Unani

Matab	Jarahat	Ilaj-bit-Tadbeer	Hifzan-e-Sehat
Any other please specify			

(d) Siddha

Maruthuvam	Sirappu Maruthuvam	Varmam Thokknam & Yoga	
Any other please specify			

(e) Homeopathy

General Homeopathy
Any other please specify

(f) Naturopathy

External Therapies with natural modalities	Internal Therapies
Any other please specify	

(g) Yoga

Ashtang Yoga Any other please specify

13. Area of the establishment (in square metres)

(a) Total area: (b) Constructed Area:

14. Out-Patient Department

Total number of Out Patient Department Clinics

Sl.No.	Speciality	Number of Rooms

15. In-Patient Department

a. Total number of beds:

b. Specialty-wise distribution of beds, please specify:

S.No.	Speciality	Number of beds

16. Biomedical Waste Management

a. Method of treatment and/or disposal of bio-medical waste

Through Common Facility Onsite Facility

Any other (please specify)

b. Whether authorization from Pollution Control Board/Pollution Control Committee obtained?

Yes No Applied for Not applicable

17. Total number of Staff (as on date of application):

Number of permanent staff: Number of temporary staff:

Category of Staff	Name	Qualification	Registration Number	Nature of Service Temporary/Permanent
Doctors				
Nursing Staff				
Para-medical Staff				
Pharmacists				
Support Staff				
Others, Please specify				

Separate annexure may be attached

18. Payment options for Registration

Fees: Demand Draft Treasury receipt

Amount (in Rs.)

Details:

I / We hereby declare that the statement stated above are true and correct to the best of my/our knowledge and I/We shall abide by the Tamil Nadu Clinical Establishments (Regulation) Act, 1997 and the Rules made thereunder.

Place:

Date:

Signature of the Authorised person of the clinical establishment

……

Acknowledgment:

Received Application for Registration from…….....……

Signature of the Receiving Officer

Name :

Date with Seal: