**INSPECTION PROFORMA**

Date of inspection . . . . . . . . . . . . . . . . . . . . . . Inspection Officer . . . . . . . . . . . . . . . . . . . . . . . . . .

1. Name and address of the institution :

2. Name of the Owner / Partner / Director :

 Managing Director etc.,

3. Type of Institution Govt. Hospital Private :

 Hosptial, Private Nursing Home, Poly

 Clinic etc.,

4. Space available :

5. Type of facility required for Registration :

6. F Form Bound Book :

7. Nominal Register pages :

8. Toilet :

9. Air Conditioner :

10. Non Reveal of sex Board,

 Punishment Board :

11. Name and Qualification Experience :

 Registration, No. of Employee i.e,

 Gynaecologist, Sonologist, Radiologist

 Genetist, Bio – Chemist etc.,

 I Certify that M/S . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . is not equipped / Purchased Ultra Sound Machine at the time of Inspection and fulfilling the basic minimum requirements and recommend that the above Institution / Hospital / Nursing Home and to Registar / Renewal / Change of address with the Appropriate Authority, Pre-conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection Act 1994).

Seal: INSPECTION AUTHORITY