Application for Provisional Registration of Clinical Establishment

[Under Section 14 of the Clinical Establishments (Registration and Regulation) Act, 2010]

1. **Name of the Clinical Establishment**: ______________________________

2. **Address**: ______________________________
Village/Town/City: ______________ Block: ______________
District: ______________ State: ______________ Pin code ______________
Tel No (with STD code): ______________ Mobile: ______________ Email ID ______________
Website (if any): ______________________________

3. Name of the owner: ______________________________
Address: ______________________________
Village/Town/City: ______________ Block: ______________
District: ______________ State: ______________ Pin code ______________
Tel No (with STD code): ______________ Mobile: ______________ Email ID: ______________

4. Name of the Person In charge ______________________________
Qualification(s): ______________________________
Registration Number: ______________________________
Name of Central/State Council (with which registered): ______________________________
Tel No (with STD code): ______________ Mobile: ______________ E-mail ID: ______________

5. **Ownership**

a) ***Government/Public Sector:*** Central Government State Government Local Government
Public Sector Undertaking Any other (please specify): ______________

b) ***Private Sector*** Individual Proprietorship Registered Partnership Registered Company
Co-operative Society Trust / Charitable Any other (please specify): ______

6. System of Medicine: (please tick whichever is applicable)
Allopathy Ayurveda Unani Siddha
Homoeopathy Yoga Naturopathy Sowa-Rigpa

7. Type of Clinical Services: General Single Specialty Multi Specialty
Super Specialty Any other (please specify): ______________

8. Type of Clinical Establishment: (please tick whichever is applicable)

a) Inpatient Outpatient Laboratory Imaging
Any other (please specify): ______________

b) **i)** ***Inpatient:*** Hospital Nursing Home Maternity Home Sanatorium
Palliative Care Primary Health Centre Community Health Centre
Any other (please specify): ______________

ii) ***Number of Beds (Inpatient):*** ______________

iii) ***Outpatient:*** Single practitioner Dispensary Polyclinic Dental Clinic
Physiotherapy / Occupational Therapy Clinic Infertility Clinic Dialysis Centre
Day Care centre Sub-Centre Mobile Clinic
Any other (please specify): ______________

iv) ***Laboratory:*** Pathology Haematology Biochemistry Microbiology
Genetics Any other (please specify): ______________

v) ***Imaging Centre:*** X ray Electro Cardio Graph (ECG) Ultrasound
CT Scan Magnetic Resonance Imaging (MRI) Any other (please specify): ______________

vi) Any other (please specify): ______________

I hereby declare that the statements made above are correct and true to the best of my knowledge. I shall abide by all the provisions of the Clinical Establishments (Registration and Regulation) Act, 2010 and the rules made there under. I shall intimate to the District Registering Authority, any change in the particulars given above.

Place: Signature of the Owner/Person in charge
Date: (Name: ______________)

V.3 Revised on 07-Aug-2012