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: _____)