

**Format -1**

**Application Form For Provisional Registration of Clinical Establishments**

1- Name of the Establishment -----  
2- **Address** : -----  
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Village/Town -----  
---  
District : ----- State ----- Pin Code -----  
---  
Tel No (With STD Code) ----- Mobile ----- Fax -----  
----  
E Mail ID ----- Website ( if any) -----  
----  
3- **Year of starting** -----  
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4- Location : Rural Urban Metropolitan  
5- **Ownership** :  
**Public Sector**  
Central Government State Government Local Government- please specify- public  
sector undertaking Railways Employee State Insurance Corporation  
(ESIC)  
Autonomous organization any other (please specify) :-----  
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**Private Sector**  
Individual Proprietorship Registered Partnership Registered Company  
Co-operative Society.  
Trust/Charitable registered under a central, provincial or state Act (please specify)-  
Any other (Please specify) -----  
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6- Name of the owner of clinical establishment:-----  
---  
Educational Qualification: -----  
---  
**Address**: -----  
--  
Village/Town -----  
---  
District : ----- State ----- Pin Code -----  
----  
Tel No (With STD Code) ----- Mobile ----- Fax -----  
----  
E Mail ID ----- Website ( if any) -----  
----  
7- Name of the person in-charge of the **Clinical Establishment**:  
Designation: ----- Educational Qualification: -----  
----  
**Address**: -----  
----  
Village/Town -----  
----  
District : ----- State ----- Pin Code -----  
----  
Tel No (With STD Code) ----- Mobile ----- Fax -----  
----  
E Mail ID ----- Website ( if any) -----  
----  
8- System of Medicine offered: (please tick whichever is applicable)  
Allopathy Ayurveda Unani Siddha Homeopathy Yoga & Naturopathy

9- **Type of Establishment:** (please tick whichever is applicable)

**Providing Out Patient Care**

Single practitioner      Polyclinic      Sub-centre      Physiotherapy Clinic  
Occupational Therapy      Infertility Clinic      Dental Clinic  
Dispensary      Dialysis Centre  
Integrated Counseling and Testing Centre (ICTC)      Wellness/ fitness Centre

Any other (please specify): -----

**Providing In Patient Care**

Hospital      Nursing Home      Maternity Home      Primary Health centre  
Community Health centre      Sanatorium

Any other (please specify): -----

Providing Testing & Diagnostic Services:

**Laboratory**

Pathology      Hematology      Biochemistry      Microbiology      Genetics      Collection Centre

Any other (please specify): -----

**Diagnostic and Imaging Centre**

X-Ray Centre      Mammography      Bone Densitometry      Sonography  
Color Doppler      CT-Scan      Magnetic Resonance Imaging (MRI)  
Electromyography (EMG)

**Any other (please specify):** -----

10- Nature of Service : (please tick whichever is applicable)

For all systems of Medicine

General      Single Specialty      Multi specialty      Super Specialty      Mobile

Any other (please specify): -----

**a) Allopathy**

General Practice      Out- Patient      Day care centre  
Emergency/casualty      ICU      ICCU  
Special Care Services for challenged persons      Blood Bank  
Organ/ Tissue Bank

Any other (please specify): -----

**b) Ayurveda**

Ausadh chikitsa      Shalya Chikitsa      Shodhan Chikitsa      Rasayana      Pathya Vyavastha

Any other (please specify): -----

**c) Unani**

Matab      Jarahat      Haj-bit-Tadbeer      Hifzan-e-Sehat

Any other (please specify): -----

**d) Siddha**

Maruthuvam      Sirappu Maruthuvam      Vaarman Thokknam & Yoga

Any other (please specify): -----

**e) Homeopathy**

General homoeopathy

Any other (please specify): -----

**f) Naturopathy**

External Therapies with with natural modalities Internal Therapies

Any other (please specify): -----

g) **Yoga** (please Specify) : -----

**INFRASTRUCTURE DETAILS**

11- Area of the establishment (in sq. meters) :

a) Total Area ----- b) Constructed area -----  
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**12- Out Patient Department:**

12-1 Total no. of OPD Clinic-----  
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12-2 Specialty- wise distribution OPD clinic

S.No.	Specialty	No. of Rooms

**13- In Patient Department:**

13-1 Total number of beds: -----

13-2 Specialty -wise distribution of beds please specify

S.No.	Specialty	No. of Beds

**14- Whether Clinical Waste Disposal License obtained from Panchayat/ Municipality/ Municipal Corporation etc ?**

Yes No Applied For

**15 Whether clearance from Pollution Control Board/ Authority obtained ?**

Yes No Applied For

**HUMAN RESOURCES**

16- Total number of staff (as in date of application):

No. of permanent staff -----No. of temporary staff ----- Please furnish the following details:-

Category of staff	Name	Qualification	Registration Number (where applicable)	Nature of service Temporary/ Permanent
Doctors				
Nursing Staff				
Para-medical staff				
Pharmacist				
Support staff				
Others, please specify				

**Separate annexure may be attached**

**17- Payment option for Registration Fees:**

Online payment Demand Draft Postal order

Any other (please specify)-----  
-

Amount (in Rs): -----  
-

Details :-----  
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Receipt No. -----  
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I -----on behalf of myself and the company

society/association/body hereby declare that the statements above are correct and true to the best of my knowledge and I shall abide by all the rules and declarations under the Clinical Establishment (Registration and Regulation) Act 2010.

I undertake that I shall intimate to the Appropriate Registration Authority of any change in the particulars given above.

Place -----

Date -----

Signature of the Authority Signatory  
Office Seal

Demand Draft in Favor of :

**Registration Authority CMO Pauri CEA**