SG1 FORM

APPLICATION FORM FOR PROVISIONAL REGISTRATION OF CLINICAL ESTABLISHMENTS

1. **Name of the Establishment** _____

2. **Address:** _____

Village/Town :_____ Taluka :_____

District:_____ State:_____ Pin code:_____

Tel No. (With STD Code)_____ Mobile:_____ Fax:_____

Email ID:_____ Website (if any): _____

3. **Year of Starting:** _____

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):

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): _____

6. **Name of The Owner of Clinical Establishment** :_____

Educational qualification:_____

Address:_____

Village/Town: _____ Taluka: _____

District: _____ State: _____ Pin Code:_____

Tel No. (With STD Code): _____ Mobile:_____ Fax:_____

Email ID:_____

7. **Name of Person In Charge of the Clinical Establishment:**_____

Designation:_____ Educational Qualification:_____

Address: _____

Village/Town: _____ Taluka:_____

District: _____ State: _____ Pin Code:_____

Tel No. (With STD Code): _____ Mobile:_____ Fax:_____

Email ID:_____

8. **Systems of Medicine offered: (please tick which ever 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 ☐ Dental clinic ☐ Dispensary
☐ Dialysis Centre ☐ Integrated Counseling and Testing Centre (ITCT)
☐ Wellness/Fitness Centre
☐ Any other (please specify): _____

Providing in Patient Care

☐ Hospital ☐ Nursing Home ☐ Maternity Home
☐ Primary Health Centre ☐ Sanatorium ☐ Community Health Centre
☐ Any Other (Please Specify):_____

Providing Testing And 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)
☐ Positron Emission Tomography (PET Scan)
☐ Electro Myo Graphy (EMG)
☐ Any Other (Please Specify):_____

Any Other (Please Specify):_____

10. Nature of Services (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 ☐ In-patient
☐ Day Care Centre ☐ Emergency/Casualty ☐ ICU
☐ ICCU ☐ Blood Bank ☐ Organ/Tissue Bank
☐ Special Care Services For Challenged Persons
☐ Any Other (please Specify): _____

b) Ayurveda

☐ Ausadh 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 ☐ please specify_____

INFRASTRUCTURE DETAILS:

11. Area of the Establishment (in sq. meters)

a) Total Area_____ b) Constructed Area_____

12. Out Patient Department

13.1 Total No. of OPD Clinics_____

13.2 Specialty wise distribution of OPD Clinic:

Sr. No.	Specialty	No. of Rooms

13. In Patient Department

13.1 Total No. of Beds_____

13.2 Specialty wise distribution of Beds, please specify:

Sr. 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 No. of Staff (as on 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				
Paramedical Staff				
Pharmacists				

Support Staff				
Others, please specify				

Separate annexure may be attached.

17. Payment options for Registration Fees:

☐ Online payment ☐ Demand Draft ☐ Postal Order

☐ Any other (please specify):_____

Amount (in Rs.)_____

Details :_____

Receipt No._____

I,_____on behalf of myself and the company/society/association/body hereby declare that the statements above are correct and true to the best 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 registering authority any change in the Particulars given above.

Place :

Date :

Signature of the authorized Signatory
Office Seal