SG1 Form

Application Form for Provisional Registration of
Clinical Establishment

A) ESTABLISHMENT DETAILS:

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 establishment:  
   (from 4 to 11 tick [ ] whichever are applicable)

4. Location:
   Metro  State Capital  City  Town  Notified Area
   Village  Any other (specify)  

5. Ownership of Services

   **Public Sector**
   a). Central Government,
   b). State Government,
   c). Local Government  Please specify:  
   d). Public sector undertaking,
   e). Railways Employee State Insurance Corporation (ESIC)
   f). Autonomous organization,
   g). Society/Not for profit companies
   h). Any other: (please specify):  

   **Private Sector**
   a). Individual Proprietorship
   b). Registered Partnership
   c). Registered Company
   d). Corporation (including a society) registered under a Central Provincial or State Act (Please specify)
   e). Trust (including Charitable) registered under a Central Provincial or State Act (Please specify)
   f). Branch of Foreign Service Provider (Please specify)
   g). Any other (Please specify):  

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

   Address:__________________________________________

   Village/Town:_________________________ Taluka:_____________________

   District:_________________________ State:_________________________ Pin code:_____________________

   Tel. No. (With STD code):_________________________ Mobile:_________________________ Fax:_____________________

   Email ID:__________________________________________

7. **Name & Designation & Qualification of person in-charge of the clinical establishment:**

   Name:__________________________________________

   Designation:__________________________________________ Qualification:__________________________________________

   Address:__________________________________________

   Village/Town:_________________________ Taluka:_____________________

   District:_________________________ State:_________________________ Pin code:_____________________

   Tel. No. (With STD code):_________________________ Mobile:_________________________ Fax:_____________________

   Email ID:__________________________________________

8. **System of Medicine offered**

   Allopathy    Ayurveda    Unani    Siddha

   Homeopathy    Yoga & Naturopathy    Dental

9. **Type of Establishment:**

   **Clinic**

   - Single Practitioner
   - Polyclinic
   - Physiotherapy clinic
   - Medical Termination of Pregnancy
   - Dental
   - Mobile Clinic
   - Any other (specify)

   **Centre**

   - Sub-Centre
   - Primary Health Centre
   - Community Health Centre
   - Urban Health Centre
   - Dispensary
   - Day Care Centre
   - Counseling Centre
   - Wellness Centre
   - Fitness Centre
   - In Vitro Fertilizer (IVT) Centre
   - Dialysis
   - Hospice Centre
   - Any other (Specify):__________________________________________
### Laboratory

<table>
<thead>
<tr>
<th>Pathology</th>
<th>Histopathology</th>
<th>Cytology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology</td>
<td>Sample Collection Centre</td>
<td>Microbiology</td>
</tr>
<tr>
<td>Genetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biochemistry</td>
<td></td>
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<tr>
<td>Any other (specify):</td>
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</tbody>
</table>

### Radiological Investigation:

<table>
<thead>
<tr>
<th>Imaging Centre</th>
</tr>
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<tbody>
<tr>
<td>Portable X'Ray</td>
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<tr>
<td>X-Ray with Computer Radiography System</td>
</tr>
<tr>
<td>Ultrasound with Color Doppler</td>
</tr>
<tr>
<td>Orthopentogram(OPG)</td>
</tr>
<tr>
<td>Positron Emission Tomography(PET) Scan</td>
</tr>
<tr>
<td>Uro-Floumetry</td>
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<tr>
<td>Any other (specify)</td>
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</tbody>
</table>

### Miscellaneous:

<table>
<thead>
<tr>
<th>Electro Cardio Graphy (ECG)</th>
<th>Echocardiography</th>
</tr>
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<tbody>
<tr>
<td>Tread Mill Test</td>
<td>Electro Myo Graphy (EMG)</td>
</tr>
<tr>
<td>Electro Ecephalo Graphy (EEG)</td>
<td></td>
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<tr>
<td>Electrophysiological Studies</td>
<td></td>
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<td>Any other (Specify):</td>
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</table>

### Blood Banks:

(A) Based on Location

<table>
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<tr>
<th>Stand Alone</th>
<th>Hospital Based</th>
<th>Any other(specify):</th>
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</table>

(B) Based on Facilities

Blood bank/ Centre having whole bloods facility only
Blood bank/ Centre having whole bloods and component facility
Blood bank/ Centre having whole bloods / OR component facility
Any other (specify):

### Hospital:

<table>
<thead>
<tr>
<th>General Practice Services</th>
<th>Maternity Home</th>
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<tbody>
<tr>
<td>Single Specialty Services</td>
<td>Multi Specialty Services</td>
</tr>
<tr>
<td>Super Specialty Services</td>
<td>Operation Theatre</td>
</tr>
<tr>
<td>Emergency Casualty</td>
<td>ICU</td>
</tr>
<tr>
<td>[CCU]</td>
<td>Any other(specify):</td>
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</tbody>
</table>

### Sanatorium:

Any other (specify):
SYSTEM OF MEDICINE:

10 Nature offered [please tick (✓) whichever is applicable]
   a). **Allopathic:**
      Specialty
      Medical  Surgical  Obstetrics & Gynecology
      Pediatrics
      Any other (specify):-________________________
   
   b). **Ayurveda:**
      Ausadh Chikitsa  Shalya Chikitsa  Sodhan Chikitsa
      Rasayana  Pathya Vyavastha  Any other:-
   
   c). **Unani:**
      Matab  Jarahat  Haj-bit-Tadbeer
      Hijzab-e-Sehat  Any other (specify):-________________________
   
   d). **Siddha:**
      Maruthuvam  Sirappu Maruthuvam
      Varman Thokknam & Yoga  Any other(Specify):-
   
   e). **Homeopathy:**
      General Homeopathy
      Any other (specify):-________________________
   
   f). **Naturopathy:**
      External Therapies with natural modalities
      Internal Therapies
      Any other (Specify):-________________________
   
   g). **Yoga:**
      Ashtang Yoga  Any other (specify):-

(C) INFRASTRUCTURE DETAILS

11 Area of the establishment (in Sq. meters):
   (a) Total Area:-_________ (b) Constructed Area:-_________

12 Out Patient Department:
   12.1 Total no. of OPD Clinics:-________________________
   12.2 Specialty-wise distribution of OPD clinic:-

<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>Specialty</th>
<th>No. of Rooms</th>
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</table>
13 In Patient Department:
13.1 Total number of beds:-

13.2 Specialty wise distribution of beds, please specify:

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<tr>
<th>Sl.No.</th>
<th>Specialty</th>
<th>No. of Rooms</th>
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14 Biomedical Waste Management:
14.1 Method of treatment and/or disposal of Bio-medical waste
Through Common Facility onsite facility
Any other (specify):

14.2 Whether authorization from Pollution Control Board/Pollution control committee obtained?
Yes    No    Applied for Not Applicable

(D) HUMAN RESOURCES

15 Total No. of Staff (as on date of application)

No. of permanent staff:- No. of temporary staff:-

Please furnish the following details:-

<table>
<thead>
<tr>
<th>Name of staff</th>
<th>Category/Designation (eg. Doctor/Nurse/Pharmacist/Support staff)</th>
<th>Qualification</th>
<th>Regn. No.</th>
<th>Nature of Service Temp/perm</th>
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NB: Separate annexure may be attached.
16 Payment option for Registration Fees:

<table>
<thead>
<tr>
<th></th>
<th>Cash Payment</th>
<th>Demand Draft</th>
<th>Postal Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount (in Rs.)</td>
<td>:</td>
<td>:</td>
<td>:</td>
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<tr>
<td>Details</td>
<td>:</td>
<td>:</td>
<td>:</td>
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<tr>
<td>Receipt No.</td>
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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 my knowledge and I shall abide by all the rule and declarations in respect of my clinical establishment.

I further declare that this clinical establishment is not and will not be used for immoral purpose. I undertake that I shall intimate to the Licensing Authority any change in the particulars given above.

Place :- ________________

Date :- ________________

Signature of Applicant

Office Seal