SG1 Form

Application Form for Provisional Registration of Clinical Establishments

(Under Section 14 of the Clinical Establishment Act, 2010)

1. **Name of the 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 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 No.:
Name of Centre/State Council with whom registered:
Tel No (with STD Code): Mobile: Email 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.* Systems of Medicine offered: (please tick whichever is applicable)

❑ Allopathy ❑ Ayurveda ❑ Unani ❑ Siddha ❑ Homeopathy ❑ 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) ❑ Hospital ❑ Nursing Home ❑ Maternity Home ❑ Sanitation ❑ Primary Health Centre
❑ Community Health Centre ❑ Any other (please specify):

ii) Number of Beds inpatients_______________________

iii) Outpatients:

❑ Single practitioner ❑ Dispensary ❑ Polyclinic ❑ Dental Clinic

❑ Physiotherapy/Occupational Therapy Clinic ❑ Infertility Clinic ❑ Dialysis Centre

❑ Day Care Centre ❑ Sub-Centre ❑ 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.

Signature of the Owner/Person In-charge
(Name____________________________)

Place:
Date: