PIMPRI CHINCHWAD MUNICIPAL CORPORATION, PIMPRI –411 018.

Private Nursing Home
For Registration / Renewal of Registration

Hospital Information FORM

1. Name of Hospital **: ……...**

2. Category of the Hospital **:** Government / Private /Trust / Pvt.Ltd.Co /any other (specify)----------

3. Address **: ……**

: ……...

4. Telephone No. **: ……**

Email **:……..**

5. Name of Hospital owner **:……..**

Qualification **: ……..**

MMC Registration No. **: ……..**

(Attach certified Xerox copy of both certificates)

UID no. of the owner **: ……..**

If trust / company / association / partnership – Attach certified copy of board of directors

(Attach separate sheet mentioning the Names, Qualification, & MMC Reg.No.of all Concerned)

6. Type of Hospital General / Surgical / Maternity / Paediatric / Ophthalmic / ENT / Ortho / ICCU /ICU /Blood Bank Multispeciality / Other Specify _____

7. Pathy Allopathic / Ayurvedic / Homeopthic / Unani / Other Specify----------

8. Total No. of beds **: ……..**

For Maternity patients **: ……..**

For other patients **: ……..**

I.C.U beds **: ……**

For Below Poverty Line patient **……..**

9. Description of building construction :

- Whether the nursing home is suitated in : Commercial`Complex / Independent Housing Society / residential area

(If in residential area Attach the N.O.C. given by Society or the Residents)

- Property tax number : ……

(attach copy of property tax paid for current year . If not – give reason)

- Total area of Nursing
- Home : **……** Sq. Feet

- No**.** of Operation Theatres available :**……**Yes / no……

- Total Area of Operation Theatre : **……** Sq. Feet

- Water Supply : Corporation / Boring / Other(specify)……..

  (**Attach the copy of water bill paid for current year)**

- Drainage system : Open space /Septic tank /Soakage pit /
  Open Drains / Underground drains

- Availability of power supply :

  What type of emergency arrangements are present in case of power failure ?
  ……

- Hospital owns Ambulance : yes/ no

  if yes, how many ..**……..**

10. Essential Equipments – (state the number available)

Boyl's Machine (If O T present) -	
Ventilators (If ICU facility present)	
Defibrillator (If OT/ICU facility present)	
Tracheostomy set	
Laryngoscope	
Endotracheal tube	
E.C.G. machine	
Pulse ox meter	
Emergancy trolly with emergency medicines	
Suction machine	
Oxygen cylinder	
Ambu bag adult	
Ambu bag paediatric	

11. M.P.C.B. Authorization No. & Date :

(Attach Copy- only for renewal of reg).

Name & designation of Person

Responsible for Bio-Medical waste management :**……..**

12 . N.O.C. from fire department PCMC attached: Yes / not applicable

(necessary for hospitals with more than 50 beds and/or height equal to or more than 15 meters)

Sign & Seal of Hospital Owner

Details of visiting doctors :

Name of Doctor	Qualifications	speciality	M.M.C. Reg. No.	Signature for attendance

(If the hospital owner is homeopathic/Ayurvedic and visiting doctors are allopathic then their affidavit for attendance on rs 100/- stamp paper must be attached)

Details of resident Doctors :

Name of Doctor	Qualifications	Pathy	M.M.C. Reg. No.

 # Details of Qualified nursing staff :

Name of sister	Qualifications	M.N.C.Reg. No.

Attach attested Xerox copies of degree/diploma certificate & MNC reg certificates

Sign & Seal of Hospital Owner

PIMPRI-CHINCHWAD MUNICIPAL CORPORAITON,PIMPRI-411 018

Application for Registration/Renewal of Registration under Section 5 of the Bombay Nursing Homes Registration Act, 1949 (Under Rules 4 and 6)

FORM A

		The replies to be written in this column
1 ❖	Full Name of the Applicant	
2 ❖	Full Residential Address of the Applicant	
3	Technical Qualifications	
4	Nationality of the Applicant	
5 ❖	Situation of the registered or principal office of the Company, Society, Association or other body Corporate	
6	Name and Other particulars of the Nursing home in respect of which the registration is applied for	
7	Place where the Nursing Home is situated	
8	Brief description of the construction size or any premises used in connection with Nursing Home and equipments used.	Give details in Application Form.
9	Whether the Nursing Home or any premises used in connection therewith are used or are to be used for purposes other than that of carrying on a Nursing Home.	
10	a) No. of beds for maternity patients	
	b) No. of beds for other patients	

11	Names, ages and qualifications of the members of the Nursing staff in the Nursing Home.	Fill in the information in a tables given in application form.
12	Place where the Nursing staff is accommodated	
13	Names, ages and qualifications of the resident or visiting physicians or surgeons in the Nursing Homes.	Fill in the information in a tables given in application form.
14	a) Whether the Nursing Home is under the supervision of a qualified medical practitioner or qualified nurse and if so, his or her name, age and qualifications	
	c) Proportion of the qualified and unqualified nurses on the nursing staff	
15 ❖	a) Whether the nursing home is under the supervision of a qualified nurse or midwife and if so, her name, age and qualifications.	
	b) Whether any unqualified medical practitioner or midwife is employed for nursing any patient in the nursing home.	
16	Whether any person of alien nationality is employed in the nursing home and if so his name and other particulars.	
17	Bed charges for the patients	
18	Whether the applicant is interested in any other nursing home or business and if so, the place where such nursing home is situated or where such business is conducted.	
19 ❖	No. and date of expiry of the certificate of registration	

I solemnly declare that the above statement are true to the best of my knowledge and belief.

Date : **Signature of the applicant.**

- **Column No. 1,2 & 5 -** In case the application is made on behalf of a company, Society, Associations or other body corporation, the name and residential address of the person in charge of the management of such Company, Society, Association or Body Corporate should be given.
- **Column No 15 (a) -** In case of a mixed home the queries should be answered with reference to maternity ward.
- **Column No. 19 -** This item is applicable when the application is made for renewal of registration.

RENEWAL OF NURSING HOME REGISTRATION
CERTIFICATE OF MONTHLY INFORMATION SYSTEM

This is certify that Dr. .....……owner Of the ……nursing home/hospital has submitted reports of following National Health Programme every month to the institution for last 3 years. i.e. from .....……to ……

		All Reports Received	Partly/ Not Reported	Not Applicable
1)	Sterilisation operations (Tubectomy/Vasectomy)	☐	☐	☐
2)	CuT insertions	☐	☐	☐
3)	Immunistion services	☐	☐	☐
4)	Antenatal case registration And A.N. Care	☐	☐	☐
5)	Cataract operations	☐	☐	☐
6)	Information on Communicatble Disease	☐	☐	☐
7)	RNTCP-DOTS therapy	☐	☐	☐

Note:- whatever applicable please tick right mark in square

Sign
Medical Officer
……..……Dispensary/Hospital

प्रतिज्ञापत्र (Affidavit)

(२० रु. चे स्टॅम्पपेपरवर नोटराईज्ड)

मी,

डॉ. श्री/श्रीमती _____ वय _____ राहणार _____

_____ आज दि. । । रोजी पिंपरी-चिंचवड महानगरपालिकेकडे माझ्या

_____ नर्सिंग होम रजिस्ट्रेशन सन ते मिळणेकरिता

अर्ज केला आहे.

१) सदरचा अर्ज फॉर्म ए व अॅप्लीकेशन फॉर्म ऑफ पीसीएमसी हे दोनही विहीत नमुन्यात भरुन दिलेले असून त्यामध्ये नमूद करण्यात आलेली सर्व माहिती व अर्जासोबत जोडण्यात आलेली आवश्यक कागदपत्रांच्या प्रती सत्य असून माझे नर्सिंग होमला परवाना मिळणेकामी / नुतनीकरण करणेकरिता मी हे प्रतिज्ञापत्र करीत आहे.

२) (अ) माझी व्यवसायाची जागा ही अधिकृत असुन त्याबाबत बांधकाम पुर्णत्वाचा दाखला माझेकडे आहे.

(ब) माझी व्यवसायाची जागा ही अनधिकृत (बिगर परवाना) बांधकाम केलेली आहे. याची मला पूर्णपणे जाणीव आहे. त्यासंबधी महानगरपालिकेने कायद्यातील तरतुदीनुसार कोणताही निर्णय घेतल्यास माझी तक्रार राहणार नाही. व्यवसायाची जागा अनधिकृत असलेने रस्तारुंदीसाठी अथवा आरक्षित असल्यास त्यासंबधी महानगरपालिकेने बांधकाम पाडण्याचा अथवा हटवण्याचा निर्णय घेतल्यास माझी कोणतीही तक्रार राहणार नाही व मी प्रतिबंध करणार नाही अथवा कायदेशीर हरकत घेणार नाही.

३) त्याचप्रमाणे व्यवसायाच्या जागेचा / इमारतीचा वापर विकासनियंत्रण नियमावलीनुसार नसल्यास अथवा मुळ आराखड्यास बाधा येत असल्यास त्वरीत नर्सिंग होम रजिस्ट्रेशन रद्द केले जाईल, याची मला जाणीव आहे.

४) (अ) सदर इमारतीची महानगरपालिकेकडून करण्यात आलेली करआकारणीची रक्कम मी भरली असून पावतीची सत्यप्रत सोबत जोडली आहे.

(ब) सदर इमारतीची महानगरपालिकेकडून नवीन इमारत असल्याने अद्यापपर्यंत करआकारणी झालेली नाही. तथापि, सदर व्यवसायाच्या इमारतीची कर आकारणी बिगर निवासी दराने करुन घेईन कर आकारणी झालेनंतर मी नियमितपणे मिळकत कर भरीन.

तसेच महानगरपालिकेस तपासणीअंती मी दिलेली माहिती खोटी असल्याने आढळून आल्यास इंडियन पिनल कोडचे कलम १९१ व १९३ मधील तरतूदीनूसार मी सात वर्षाचे कारावासाचे शिक्षेस पात्र राहीन व मुंबई नर्सिंग होम कायदा १९४९ नुसार दिलेले नर्सिंग होम रजिस्ट्रेशन रद्द करण्यास मी पात्र असून माझेवर उक्त कायद्यातील तरतूदीनूसार गुन्हा दाखल करण्यास तसेच मनपा मार्फत रु.रु.१,०००/- दंड भरण्यास मी पात्र आहे व मनपा अधिनियम १९४९ चे कलम ३७६ (अ) अन्वये माझा व्यवसाय बंद करणेत येईल याची मला जाणीव आहे.

पिंपरी लिहून देणार

दिनांक : / /२०० नांव : _____

टिप - मुद्दा क्र. २ व ४ अ व ब पैकी लागू असेल ते प्रतिज्ञापत्रात नमूद करावे.