**(See Rule-4(a))**

**APPLICATION FOR REGISTRATION**

**OF TELANGANA ALLOPATHIC PRIVATE MEDICAL CARE ESTABLISHMENT**

**(To be submitted in Duplicate)**

1. **Name & Address of the Allopathic Private Medical**

**Care Establishment**

1. **Name of correspondent or any Authorized person**

**For correspondence**

1. **Name and address of the Society/Trust & date on**

**Which it was established**

1. **Whether the accommodation is owned by the**

**Establishment or on lease/rent. If so, please furnish**

**The period of lease/rent along with the**

**Documentary proof**

**(please Enclose the relevant copies)**

1. **The date of establishment of Medical Care**

**Establishment a) Open area b) Constructed area**

1. **Total area of Establishment, (One set of**

**Photographs of the premises with its functional**

**Areas to be furnished)**

1. **Bed Strength**
2. **Types of services offered (1) Basic (2) Specialty**

**(3) Super Specialty (4) Diagnostics**

1. **Name of Doctors, along with Registration Number**

**Allotted by MCI/APMC (Please Enclose the details)**

1. **Names of qualified Nursing Staff, with their of**

**Registration numbers of NCI/any other board**

**(Please Enclose the details)**

1. **Names of Para Medical Staff & their Registration**

**Numbers (list to be enclosed)**

1. **No of supporting staff (list to be enclosed)**
2. **No.Specialist available**

**(Please Enclose the details)**

1. **The list of Equipment and furniture available**

**(please Enclose the details)**

1. **Labour room with pediatric care facilities**
2. **Operation Theatres**
3. **Diagnostic Facilities including Clinical Laboratory**

**And Imaging facilities**

1. **Whether Registration is sought for main facility, or**

**Branches also, If so details (separate application**

**Shall be submitted for each branch)**

1. **The Financial position of the Hospital/Institute**

**(enclose Audit report of the last two years)**

1. **Any other information relating to Hospital**
2. **Declaration on stamp paper for willingness to**

**Comply with the prescribed rules is enclosed Yes / No.**

1. **Particulars of the Registration fee paid**

**(D.D.No. Name of the bank, and Date)**

**I here declare that the information furnished above is true to the best of my knowledge and belief and if it is found that any wrong information is furnished or suppressed the material facts, I will take full responsibility for the consequential action as per law.**

**(Signature)**

**(Name and Designation and full address**

**With official seal)**

**Date:**

**Place:**

**A.P.Allopathic Private Medical Care Establishment Registration Act R.R.District.**

**DOCUMENTS FOR REGISTRATION**

1. **Hospital, Color Photo Graph**
2. **Owner Director photo or Allopathic Doctor who is in 24 hrs, Service**
3. **Xerox copy of Medical Council Registration of Doctor.**
4. **I own premises provide Tax receipt or Telephone Bill (if owned building latest**

**tax paid receipt)**

1. **If leases – leased agreement**
2. **APNA registration Xerox Copy**
3. **IMA Membership Xerox copy**
4. **DD in Favour of District Registration Authority (DRA & DM&HO, R.R.District)**
5. **Fees as per proforma given below.**
6. **No. of Doctors List with name, qualification & Registration No allotted by**

**MCA/APMC & Xerox copy of Certificates**

1. **No.of Para Medical Staff list with name, qualification & Registration No & Xerox   
    copy of Certificates**
2. **No.of Para Medical Staff list with name, qualification & Registration No & Xerox   
    copy of Certificates**
3. **No. of Supporting Staff list with name**
4. **No.of Specialist available List with Name, qualification & Registration No   
    allotted by MA/APMC & Xerox copy of Certificates.**
5. **List of Equipment & Furniture**
6. **Declaration Non judicial stamp paper with notarized**
7. **Previous (Two years) Audit report**
8. **All the documents and application form submitted in 1+1 with Spiral Binding**
9. **Ph.No. of Allopathic Medical Care Establishment**
10. **Ph.No. of Correspondence Allopathic Medical Care Establishment**
11. **All documents as per the order given above.**
12. **Copy of Rates charges for each types of services and same display at the   
     reception counter in both the local and English language.**
13. **Display of rates given in Appendix – III**
14. **Bill-Wastage Management Certificate**
15. **FIRE NOC from GHMC Hyderabad**
16. **Tariff Display (4 X 6) Display at reception & Photograph**

**FEES PARTICULARS:-**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sl.**  **No.** | **Description of Establishment** | **Annual Fees** | **Registration Fee for (5 years Fees payable if favour of DRA & DM&HO through DD only)** |
| **1** | **Clinics/consolation rooms (solo practitioners)** | **250/-** | **1250/-** |
| **2** | **Poly clinics (Group Practitioners)** | **500/-** | **2500/-** |
| **3** | **Hospital/Nursing Homes less than 20 beds** | **750/-** | **3750/-** |
| **4** | **Hospital/Nursing Homes less than 21 to 50 Beds** | **1500/-** | **7500/-** |
| **5** | **Hospital/Nursing Homes less than 51 to 100 Beds** | **2000/-** | **10000/-** |
| **6** | **Hospital/Nursing Homes less than 101 to 200 Beds** | **3000/-** | **15000/-** |
| **7** | **Hospital/Nursing Homes with more than 200 Beds** | **7500/-** | **37500/-** |
| **8** | **Diagnostic Centers (Basic Lab facilities)** | **500/-** | **2500/-** |
| **9** | **Diagnostic Centers with hi-end equipment (CT etc)** | **2000/-** | **10000/-** |
| **10** | **Physiotherapy units** | **750/-** | **3750/-** |

**DECLARATION PROFORMA (in Rs. 10 or Rs. 20 Stamp paper)**

**I hereby declare that the information furnished above is true to the best of my knowledge and belief and it is found that any wrong information is furnished of suppressed the material facts, I will take full responsibility for the consequential action as per law. The management of the Hospital will abides and follows the guidelines issued in the G.O.Ms.No.135 Health Medical & Family Welfare, (K2 Dept) dt. 28.04.2007 and instruction issued thereon by Government from time to time in the matter.**

**Signature of the Owner/Managing Director**

**Notarized /concerned Allopathic Establishment**