



5. **Systems of Medicine offered: ( please tick whichever is applicable )**

Allopathy  Ayurveda  Unani  Siddha  Homeopathy   
 Yoga & Naturopathy

6. **Services Provided: ( please tick whichever is applicable )**

Inpatient  Outpatient  Laboratory  Imaging Centre

Any other (please specify): 

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a) Category of Clinical Services: General  Single Specialty  Multi Specialty   
 Super Specialty

7. **Type of Establishment: ( please tick whichever is applicable )**

a) Inpatient: Hospital  Nursing Home  Maternity Home  Primary Health Centre   
 Community Health Centre  Sanatorium  Day Care Centre

b) Number of Sub-Centre: 

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c) Number of Beds: 

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d) Outpatient: Single practitioner  Polyclinic  Sub-Centre  Physiotherapy  
 Clinic  Occupational Therapy  Infertility Clinic  Dental Clinic   
 Dispensary  Dialysis Centre

Any other (please specify) 

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e) Laboratory: Pathology  Haematology  Biochemistry  Microbiology   
 Genetics  Collection Centre

Any other (please specify): 

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f) Imaging Centre: (please specify): 

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Special diagnostics: (please specify): 

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I hereby declare that the statements above are correct and true to the best of my knowledge and 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.

DD MM YY  

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Signature of the Authorized Signatory

**Note:- Person in charge Qualification Certificate Attested Photo Copy thil tel tur.**