OFFICE OF THE STATE MEDICAL COMMISSIONER
EMPLOYEES' STATE INSURANCE CORPORATION

REGIONAL OFFICE, PANCHDEEP BHAWAN, JANPATH, UNIT-IX, BHUBANESWAR-22

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Empanelment of I.M.P./Private Hospitals and Nursing Homes in Odisha

Applications are invited from Registered Medical Practitioners (Modern Medicine with minimum M.B.B.S Degree) for empanelment as Insurance Medical Practitioner (IMP) and Private Nursing Homes & Hospitals located in centres of all districts of Odisha for providing primary health services with basic investigations to the Insured Persons and their families living in areas where new implementation of the ESI scheme is under process. Applicant for IMP should be less than 67 years of age. Contract period shall be one year, renewable every year for a maximum period of three years. Fixed capitation fee of Rs.300/- per IP family unit per annum will be paid along with other remuneration, as per rules. The Application form may be downloaded from the Regional Office website **www.esicorissa.nic.in**. Duly filled in application form may be submitted to the Office of State Medical Commissioner, ESI Corporation, Panchdeep Bhawan, Janpath, Unit-IX, Bhubaneswar-751022 by 19.02.2016 upto 2.00 P.M. Application received after due date and time and without necessary enclosures shall be summarily rejected.

Decision of the competent authority in this regard shall be final and binding in all respects.

State Medical Commissioner,
ESI Corporation,
Bhubaneswar, Odisha

Annexure-I

FORMAT OF APPLICATION FOR INCLUSION IN MEDICAL LIST AS INSURANCE MEDICAL PRACITIONER UNDER THE EMPLOYEES' STATE INSURANCE CORPORATION

1. Name in full (in block letters)

   _____

2. Date of Birth_____

3. Sex _____

4. Name of spouse, if married _____

5. Next of kin/Nominee

6. Medical qualification and other post graduate qualification :-

University/Examination Board	**Particulars of Examinations**	**Date of Examinations**

7. (a) MCI/State Medical council Registration No. _____

8. Full residential address _____

   _____

   _____

9. Email Id: _____Phone Nos. _____

10. Full address of Clinic : _____

    _____

11. Date from which practicing in the locality _____

12. Accommodation in Clinic _____

Room	**Area in sq. feet**	**Function**

13. Do you have :
    (1) A separate consultation room ?
    (2) Space where patients can wait?
    (3) Your own dispensing arrangements?
    (4) A laboratory facility?
    (5) A toilet
    (6) A computer with or without internet facility?

15. Clinic timing _____

16. Availability of ancillary staff in dispensary/Clinic ?

Designation	Full time	Part Time

17. Have you ever been debarred/penalized by the MCI/State Medical council ?

18. If selected on the Medical List, how many insured persons are you prepared to have on your list (max: 2000)

19. Status of Clinic (please tick)
    1. Self owned
    2. Rented

20. State equipment and appliances maintained in your dispensary in a separate sheet.

21. Experience as General Medical Practitioner*:

Period		Address of the Clinic
From	To	

*The applicant should have at least experience of 2 years as general practitioner.

22. Whether you were previously an IMP under ESI Scheme? If so, please state Code No. and reason for withdrawal of name from Medical List.

23. Have you applied previously? If so, what date, month and year?

Documents required to be attached:

(a) Registration Certificate
(b) Degree certificate
(c) SSC/School leaving certificate showing date of birth
(d) Proof of documents showing ownership/tenancy of the clinic. (Ownership papers, rent receipt, rent agreement, electricity bill and water connection bill, if available)
(e) All copies of above documents are to be self attested before submission.

DECLARATION

I, _____, a candidate for inclusion in the Medical List as an Insurance Medical Practitioner under the Employees' State Insurance Scheme declare that the particulars given above are true and correct to the best of my knowledge and belief.

I agree to abide by the terms & conditions of service if included in the Medical List.

Date

Place Signature

Annexure II

FORMAT OF APPLICATION FOR EMPANELMENT OF PRIVATE HOSPITAL/ NURSING HOME UNDER EMPLOYEES STATE INSURANCE SCHEME

1. Name of the Hospital : _____

2. Full Address :
   _____
   _____
   _____

3. E-mail ID : _____ Phone Number : _____

4. Accommodation in the Hospital

Room	Area in Sq. Ft.	Function

5. Details of Full Time Doctors

Sl. No.	Name of Doctor	Qualification	Experience*

*The Full Time doctor should have at least experience of 2 years as general practitioner.

6. Do you have : (1) A separate consultation room ?
   (2) Space where patients can wait ?
   (3) Your own dispensing arrangements ?
   (4) A laboratory facility ?
   (5) A toilet
   (6) A computer with or without internet facility ?
7. No. of Beds : _____

8. Hospital timing: _____

9. Status of Hospital : Self Owned Building/ Rented Building

10. Whether Registered by the Appropriate Authority of the Central Government/ State Government : Yes / No (If yes, please provide copy of the relevant registration certificate)

11. State equipment and appliances maintained with your Hospital in a separate enclosure

Documents required to be attached :

(f) Registration Certificate
(g) No Objection/ Clearance certificate from concerned department.
(h) All copies of above documents are to be self attested before submission.

DECLARATION

The declarations stated in point no.1 to point no. 11 above are true and correct to the best of my knowledge and belief.

Date
Place

Signature & Seal