Format for Empanelment of Hospitals

Name of the City where the Hospital is located

Name of the Hospital

Address of the Hospital

Tel./ Fax/ E-mail

Telephone No.	
Fax	
E-mail ID	
Name and Contact Details of Nodal Person	

Whether NABH accredited

Whether NABH applied for

Details of Accreditation and Validity Period

Super Speciality Facility applied for (Please tick the appropriate row in the table provided below)

Name of Super Speciality Facility	Applied For (Please tick the appropriate row)
Oncology and Onco Surgery	
Pediatric Surgery	
Cardiology and Cardio Thoracic Vascular Surgery (CTVS)	
Nephrology and Urology	
Neurology and Neuro Surgery	
Gastro Enterology and GI Surgery	
Endocrinology and Endocrine Surgery	
Burns and Plastic Surgery	
Reconstruction Surgery	

Total Number of Beds | | |

Categories of Beds with number of Total beds available in the following type of wards

Casualty/ emergency Ward | |

ICCU/ICU | |

Semi Private (2-3 Bedded) | |

General Ward (4-10) | |

Others | |

Total Area of the Hospital

Area allotted to OPD | | | |

Area allotted to IPD | | | |

Area allotted to Wards | | | |

Nursing Care

Total No. of Nurses | |

No. of Para Medical staff | |

Category of Bed/Nurse Ratio

Alternate Power Source Yes/ No

Bed Occupancy Rate

General Bed

Semi Private Bed

Private Bed

Availability of Doctors

1. No. of In House Doctors

2. No. of In House Specialists/ Consultants

Laboratory Facilities Available — Pathology, Biochemistry/ Microbiology/ Any Other

Imaging Facility Available — Yes/ No

No. of Operation Theatres

Whether there is OT for Specific cases — Yes/ No

Supportive Services

Boilers/ Sterilisers

Ambulance

Laundry

House keeping

Canteen

Gas Plant

Dietary

Others

Blood Bank

Pharmacy

Physiotherapy

Signature of Applicant or Authorised Agent

CERTIFICATE OF UNDERTAKING

1. It is certified that the particulars given above are correct and eligibility criteria are satisfied

2. That Hospital/ Medical Establishment shall not charge ESI beneficiaries higher than the CGHS notified rates or the rates charged from other patients who are not ESI beneficiaries.

3. That the rates have been provided against a facility/ procedure/ investigation actually available at the Organization.

4. That if any information is found to be untrue, Hospital/ Medical Establishment would be liable for de-recognition by ESIC. The Organisation will be liable to pay compensation for any financial loss caused to ESI or physical and or mental injuries caused to its beneficiaries.

5. That the Hospital/ Medical establishment will pay damage to the beneficiaries if any injury, loss or part of death occurs due to gross negligence.

6. That Hospital/ Medical establishment has not been derecognized by CGHS or any State Government or other organizations

7. That no investigation by the Central Government/ State Government or any Statutory Investigating agency is pending against the Hospital/ Medical Establishment.

8. The Hospital/ Medical Establishment agrees to the terms and conditions of the advertisement

Signature of Applicant or Authorised Agent

Enclosures

1. Copy of legal status, place of registration and principal place of business of the health care Organisation or partnership firm, etc.

2. A copy of partnership deed/ memorandum and articles of association, if any.

3. Copy of the license for running Blood Bank

4. Copy of the documents full filling statutory requirements

Signature of Applicant or Authorised Agent