



SCHEDULE I

Application Form for Registration of Health Care Establishment (Section 7(i) and Rules 3 under NHCE Act 1998)

(NB: Attached separate Annexure wherever Applicable)

Part I: ESTABLISHMENT DETAILS

1. Name of the Health Care Establishment:

Full Name in Capital Letters

2. Full Address of the Health Care Establishment:

Particulars	Details
a. House No	
b. Street/ Ward/ Village/ Town	
c. Block	
d. District	
e. State	
f. Pin code	
g. Tel No (with STD code)	
h. Mobile No	
i. Fax No	
j. Email ID	
k. Website (if any)	

3. Type of Proprietorship of the Health Care Establishment:

Particulars	Yes/ No	Details
a. Individual Proprietorship		Provide Registration Certificate, MoA, Bye-Laws, MoU, etc wherever applicable as Annexure: Part I .3
b. Registered Partnership		
c. Registered Company		
d. Society/ Trust (including Charitable) registered under a Central, Provincial or State Act.		
e. Any other (please specify)		

4. Details of the Proprietor of the Health Care Establishment:

Particulars	Details
a. Name of the Proprietor of the Health Care Establishment	
b. Full Address	
• House No	
• Street/ Ward/ Village/ Town	
• Block	
• District	
• State	
• Pin code	
• Tel No (with STD code)	
• Mobile No	
• Fax No	
• Email ID	

5. Month and Year of starting of the Health Care Establishment:

DD	MM	YYYY

6. Date of issue of First License (in case renewal):

Regd No	DD	MM	YYYY

7. Fee Deposit:

Particulars	Amount	DD No
Application Fee through Treasury Challan (Enclosed)		
Inspection Fee (Demand Draft in favour of the Principal Director)		



Part II: TYPE OF HEALTH CARE ESTABLISHMENT

1. Type of HCE (Circle wherever applicable):

Inpatient		Outpatient		Mobile Clinic		Laboratory		Imaging	
Static	Mobile	Static	Mobile	Static	Mobile	Static	Mobile	Static	Mobile
Any Others (please specify separately as Annexure: Part II.1)									

2. Clinic And Hospitals

Service	Yes/ No	Service	Yes/ No
General		Single Super Speciality	
Single Speciality		Multi Super Speciality	
Multi Speciality		Others (please specify separately as Annexure: Part II.2)	

3. Hospital Level as per Categorization of HCE (Circle wherever applicable):

Level 1	Level 2	Level 3	Level 4 (Teaching)

4. No of Beds (Circle wherever is applicable):

Upto 30 Beds	31-50 Beds	51-100 Beds	101-200 Beds
201-300 Beds	301-500 Beds	Above 500 Beds	Not Applicable
Any Others (please specify separately as Annexure: Part II.4)			

5. Systems of Medicine offered by the HCE (Circle wherever applicable):

Allopathic		Ayurveda		Unani		Siddha	
Homeopathy	Yoga	Naturopathy	Others (please specify separately as Annexure: Part II.5)				

6. Discipline offered by the HCE:

a. Speciality Discipline:

Discipline		Yes/ No
1. Medical Specialties – for which candidates must possess recognized PG degree (MD/ Diploma/ DNB or its equivalent degree)	1) Anesthesiology	
	2) Aviation Medicine	
	3) Community Medicine	
	4) Dermatology, Venerology and Leprosy	
	5) Family Medicine	
	6) General Medicine	
	7) Dialysis	
	8) Geriatrics	
	9) Immuno Haematology and Blood Transfusion	
	10) Nuclear Medicine	
	11) Pediatrics	
	12) Physical Medicine Rehabilitation	
	13) Psychiatry	
	14) Radio-diagnosis	
	15) Radio-therapy	
	16) Rheumatology	
	17) Sports Medicine	
	18) Tropical Medicine	
	19) Tuberculosis & Respiratory Medicine or Pulmonary Medicine	
2. Surgical specialties - for which candidates must	1) Otorhinolaryngology	
	2) General Surgery	

possess, recognized PG degree (MS/Diploma/DNB or its equivalent degree)	3) Ophthalmology	
	4) Orthopedics	
	5) Obstetrics & Gynecology	
	6) In Vitro Fertilization (IVF)/ART Services	
3. Medical Super specialties	1) Cardiology	
	2) Clinical Hematology	
	3) Clinical Pharmacology	
	4) Endocrinology	
	5) Immunology	
	6) Medical Gastroenterology	
	7) Medical Genetics	
	8) Medical Oncology	
	9) Neonatology	
	10) Nephrology	
	11) Neurology	
	12) Neuro-radiology	
4. Surgical Super-specialities	1) Cardiovascular thoracic Surgery	
	2) Urology	
	3) Neuro-Surgery	
	4) Paediatrics Surgery	
	5) Plastic & Reconstructive Surgery	
	6) Surgical Gastroenterology	
	7) Surgical Oncology	
	8) Endocrine Surgery	
	9) Gynecological Oncology	
	10) Vascular Surgery	
5. Any other (please specify separately as Annexure: Part II.6.a)		

b. Dentistry (Circle wherever applicable):

Oral and maxillofacial surgery	Oral medicine and radiology	Orthodontics	Conservative dentistry and Endodontics
Periodontics	Pedodontics and preventive dentistry	Oral pathology and Microbiology	Prosthodontics and crown bridge
Public health dentistry	Others (please specify separately as Annexure: Part II.6.b)		

c. Diagnostic Centre (Circle wherever applicable):

(i). Laboratory					
• Pathology	Haematology	Histopathology	Cytology	Genetics	Samples Collection Centre
• Biochemistry					
• Microbiology					
• Virology					
• Molecular Biology					
• Genetic Labs					
• Other (please specify separately as Annexure: Part II.6.c.i):					
(ii). Imaging Centre					
• General Radiology	Portable X ray	Conventional X Ray		Digital X Ray	CT Scan
	X Ray with computed system	Radiography		Orthopantogram (OPG)	Bone Densitometry
• Interventional radiology	Angiography		Uro-flowmetry		
• Electromagnetic Imaging	Magnetic Resonance Imaging (MRI)			Positron Emission Tomography (PET) Scan	
• Ultrasound	Ultrasound			Ultrasound with Color Doppler	
• Any other (please specify separately as Annexure: Part II.6.c.ii)					
(iii). Miscellaneous					
Electro Cardio Graphy (ECG)	Echocardiography	Tread Mill Test	Electro Myo Graphy (EMG)		
Electro Encephalo Graphy (EEG)	Electrophysiological studies	Mammography	Others (please specify separately as Annexure : Part		

		II.6.c.iii)
iv).	Collection centers for the clinical labs and diagnostic centres shall function under registered clinical establishment	

d. Allied Health Professions (Circle wherever is applicable):

Audiology	Behavioral health (counseling, marriage and family therapy)	Exercise physiology
Nuclear medicine technology	Medical Laboratory Scientist	Dietetics
Occupational therapy	Optometry	Orthoptics
Orthotics and prosthetics	Osteopathy	Paramedic
Podiatry	Health Psychology	Physiotherapy
Radiation therapy	Radiography / Medical imaging	Respiratory Therapy
Sonography	Speech pathology	Others (please specify separately as Annexure: Part II.6.d)

e. Organ /Tissue Bank (Circle wherever is applicable):

Blood Bank	Blood Storage Unit	Others (please specify separately as Annexure: Part II.6.e)
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f. Ayurveda (Circle wherever is applicable):

Ausadh Chikitsa	Shalya Chikitsa	Shodhan Chikitsa	Rasayana
Pathya Vyavastha	Others (please specify separately as Annexure: Part II.6.f)		

g. Unani (Circle wherever is applicable):

Matab	Jarahat	Ilaj-bit-Tadbeer
Hifzan-e-Sehat	Others (please specify separately as Annexure: Part II.6.g)	

h. Siddha (Circle wherever is applicable):

Maruthuvam	Sirappu Maruthuvam	Varmam Thokknam & Yoga
Others (please specify separately as Annexure: Part II.6.h)		

i. Homeopathy (Circle wherever is applicable)

General Homeopathy	Others (please specify separately as Annexure: Part II.6.i)
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j. Naturopathy (Circle wherever is applicable):

External Therapies with natural modalities	Internal Therapies
Others (please specify separately as Annexure: Part II.6.j)	

Yoga (Circle wherever is applicable):

Ashtang Yoga	Others (please specify separately as Annexure: Part II.6.k)
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Part III: INFRASTRUCTURE DETAILS

1. Area of the establishment (in sq ft):

Particulars	Details
a. Total area	
b. Constructed area	
c. Power Supply	
d. Water supply	
e. Sanitation	
f. Facility for Disabled Persons	
g. Facility for Parking Space	
h. Others (please specify separately as Annexure: Part III.1)	

2. Out Patient Department:

- a. Total no. of OPD Clinics: _____
- b. Specialty-wise distribution of OPD Clinic:

SI No	Specialty	SI No	Specialty

Provide separately as Annexure: Part III.2

3. In Patient Department:

- a. Total number of beds: _____
 b. Specialty-wise distribution of beds:

Sl No	Specialty	No of Beds
Provide separately as Annexure: Part III.3		

Part IV: HUMAN RESOURCES

1. Total number of Staff (as on date of application):

Category of Staff	Type of Employment		
	No of Permanent Staff	No of Temporary/ Visiting Staff	Total
Doctors			
Nurses			
Technicians			
Pharmacists			
Administrative Staff			
Others (please specify separately as Annexure: Part IV.1)			

2. Details of Employees of the Health Care Establishment:

Category of Staff	Name of the Staff	Date of Appointment	Qualification	Registration No (Wherever applicable)	Nature of Service (Permanent/ Temporary/ Visiting)
Doctors	Provide the details as per the format along with Appointment Order and Self Attested Certificates of Qualification and Registration Certificate (if applicable) for each employee as Annexure: : Part IV.2				
Nurses					
Technicians					
Pharmacists					
Administrative Staff					
Support Staff					
Others (Please Specify)					

Part V: OTHERS

1. Referral Transport/ Ambulance Services:

Particulars	Yes/ No	Details
a) Referral Transport / Ambulance Type (Basic or Transport/ Advance)		Provide as Annexure: Part V.1
b) Other Transport Facilities		
c) Others (please specify)		

2. Medical Oxygen/ Gases:

Particulars	Yes/ No	Details
a) Medical Oxygen		Provide as Annexure: Part V.2
b) Other Medical Gases		

3. Sterile Supply services:

Particulars	Yes/ No	Details
a) Sterile services		Provide as Annexure: Part V.3

4. Laundry services:

Particulars	Yes/ No	Details
b) Laundry services		Provide as Annexure: Part V.4

5. Food (Canteen/Kitchen etc) services:

Particulars	Yes/ No	Details
a) Food services		Provide as Annexure: Part V.5

6. Signage:

Particulars	Yes/ No	Details
a. Display of appropriate signage		Provide Photographic Evidence as Annexure: Part V.6
b. Board displaying the name of the hospital at a prominent location		
c. Placement of Directional signage within the facility to guide the patient(s).		
d. Safety Hazard and Caution signs, for e.g. hazards from electrical shock, inflammable articles, radiation etc shall be displayed at appropriate places, and as applicable under law.		
e. Others (please specify)		

7. Display of the Citizen Charter:

Citizen Charter shall contain, at the least, the following information:

Particulars	Yes/ No	Details
Name/ Address/ Contact Details with Registration Details of the Establishment		Provide Photographic Evidence as Annexure: Part V.7
Timings of the facility		
List of Doctors with Registration No		
List of various available services with Fee/ costs/ rates		
List of Exempted Service Charges (If any)		
Mandatory information such as under PNDT Act etc		
Patients' rights & responsibilities		
Important contact numbers such as Blood Banks, Fire Department, Police and Ambulance Services available in the nearby area.		

8. Content of Medical Record:

Medical record shall contain, at the least, the following information:

Particulars	Yes/ No	Details
Name & Registration number of treating doctor		Enclose a sample copy as Annexure: Part V.8
Name, demographic details & contact number of patient		
Relevant Clinical history, Assessment and re-assessment findings, nursing notes and Diagnosis		
Investigation reports		
Details of medical treatment, invasive procedures, surgery and other care provided		
Applicable consents		
Discharge summary		
Cause-of-death certificate & Death Summary (where applicable)		
Others (Please Specify)		

9. Informed Consent/Consent Guidelines:

The informed/General consent shall at the least contain the following information in an understandable language and format.

Particulars	Yes/ No	Details
Name of the patient/ guardian (in case of minor/mentally disabled)		Enclose a sample copy as Annexure: Part V.9
Registration number of patient		
Date of admission		
Name & Registration number of treating doctor		
Name of procedure/operation/investigation/blood transfusion /anaesthesia/ potential complications		
Others (Please Specify)		
Signature of patient/guardian with date and time		

10. Discharge Summary:

Discharge Summary shall contain, at the least, the following information:

Particulars	Yes/ No	Details
Name & Registration number of treating doctor		Enclose a sample copy as Annexure:
Name, demographic details & contact number of patient, if available		
Registration number of patient		

Date of admission and discharge		Part V.10
Relevant clinical history, assessment findings and diagnosis		
Investigation results,		
Details of medical treatment, invasive procedures, surgery and other care provided		
Discharge advice (medications and other instructions).		
Instruction about when and how to obtain urgent care.		
Others (Please Specify)		
Signature of the Practitioner with date and time		

11. Details of arrangement of disposal of hospital waste:

a. Method of treatment and /or disposal of Bio-medical waste			
Through Common Facility	Through Onsite Facility	Any other (please specify)	
b. Whether authorization from State Pollution Control Board obtained?			
Yes	No	Applied For	Not Applicable

NB: Provide details of waste management as Annexure: Part V.11

12. Facility for Quality Assurance (Please Specify):

Particulars	Details

NB: Provide as Annexure: Part V.12

13. Statutory Compliance for time being in force (Attested copies to be produced wherever applicable):

Particulars	Yes/ No	Details
1) NHCE Act Registration No (in case renewal)		Provide Copy of the Certificate/ Document issued by the Competent Authority separately as Annexure: Part V.13 (1-23)
2) Trade License		
3) NOC/ Certificate from Pollution Control Board		
4) NOC/ Certificate from Fire Department		
5) NOC/ Certificate from Power Department		
6) NOC/ Certificate from PWD		
7) NOC/ Certificate from PHED		
8) AERB License		
9) Pharmacy License		
10) Food Safety License		
11) Narcotic Drug License		
12) Medical Gases License		
13) Blood Bank/ Blood Storage License		
14) Boilers License		
15) NOC for Generator set from Pollution Control Board		
16) MTP Act		
17) P & PNDDT Act		
18) Sale Tax Registration		
19) PAN		
20) TIN		
21) Registration No (in case of Society, Trust, Company etc)		
22) Labours Laws eg: EPF Act, Payment of Wages Act, Minimum Wages Act, Payment of Bonus Act, ESI Act in addition to Regulations of Manual of Standing Orders.		
23) Others (Please Specify)		

14. UNDERTAKING:

I,on behalf of (Name of the Health Care Establishment)

.....
.... (Name of the Health Care Establishment) and as Proprietor/ Authorised Representative of the company/ society/ association/ body of the said Health Care Establishment hereby declare that the statements furnished above are correct and true to the best of my knowledge.

2. I certify that the above mentioned Health Care Establishment has not employed any doctors, nurses or paramedics or any other employees in the employment of the State Government.

3. I undertake that I shall inform the Nagaland Health Care Establishment Authority of any changes in the particulars given above.

4. I comply with the minimum standards under Nagaland Health Care Establishment Act for the services provided by me/ us.

5. I shall abide by all the provisions made under the Nagaland Health Care Establishment Act.

Place:
Signatory
Date:

Signature & Name of the Authorized

Office Seal

**REQUIREMENT FOR REGISTRATION/RENEWAL UNDER NAGALAND HEALTH CARE ESTABLISHMENT
ACTS 1997**

1. Application for Registration/Renewal from Proprietor (address to Principal Director)
2. Forwarding letter from Chief Medical Officer(Concerned Districts)
3. Appointment order of all the employees from Proprietor.
4. Registration certificate of Doctors from Nagaland Medical Council and their specialities if any, Registration Certificate of BDS (Dental) under Nagaland Dental Association and their Internship.
5. Registration of Certificate of B.sc (Nursing) GNM , ANM from Nagaland Nursing Council with duly self attested.
6. Registration Certificate of Pharmacists from Nagaland Pharmacy Council along with latest Renewal Pharmacy Licence/Retention.
7. Photocopy of latest licence for Renewal. If registered under NHCE Acts 1997.
8. Latest Trade Licence , Certificate/NOC from Pollution Control ,Bio-Waste Management ,Fire & Emergency Services , Power ,PWD(Housing),PHED License of AERB if X-ray, CT Scan, Ultrasound etc are available, Food safety, PNDDT Act If Obys & Gynae Doctor is available , Blood storage License ,
9. Treasury challan according to number of bed, address to Principal Directors Directorate of Health & Family Welfare with (Head of Accounts -0210/Med & health).
10. Photography of Hospital , Nursing Home , Clinic, Diagnostic Centre in A4 Size Paper (External & Internal View)
11. An original copy along with 2(two) photocopies of each documents
12. Registration form amounts to Rs.100/- (Per form)

SCHEDULE II.

APPLICATION FEE CHARGEABLE FOR GRANT OF LICENCE AND REGISTRATION WITH THE HEALTH AUTHORITY, SUBJECT TO REVISION FROM TIME TO TIME.

1.	Clinic	Rs. 500.00
2.	Polyclinic :	Rs. 1500.00
3.	Dispensing and Consulting:	Rs. 500.00
4.	Day Care Center	Rs. 1000.00
5.	Nursing Homes and Maternity Homes:	
	a. Up to 10 beds:	Rs. 1500.00
	b. 11 – 30 beds:	Rs. 2000.00
	c. 31 to 50 beds:	Rs. 3000.00
	d. 51 to 100 beds:	Rs. 5000.00
	e. Above 100 beds:	Rs. 10000.00
6.	Diagnostic units:	
	a. Laboratory with only clinical Biological/Microbiological/ Biochemical testing facilities:	Rs. 1000.00
	b. Radiological facilities:	Rs. 1000.00
	c. CT Scan, Ultrasound and other diagnostic facilities:	Rs. 2500.00
7.	Physiotherapy clinic/center	Rs. 1000.00

Treasury challan

Head of Accounts : 0210 (Med & Health)