SINGHANIA UNIVERSITY

Established U/S 2(f) of UGC Act, 1956 website: www.singhaniauniversity.ac.in
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EDUCATION FOR ALL, HEALTHCARE FOR ALL, EMPLOYMENT FOR ALL, AUTONOMOUS, MULTI TASKING, INTEGRATED & CORRUPTION FREE EDUCATION SYSTEM IS THE BASIS OF DEVELOPMENT

APPLICATION FORM FOR AFFILIATION/COLLABORATION/RECOGNITION OF HOSPITALS FOR RUNNING OF MEDICAL COURSES U/S 2(a) OF THE INDIAN MEDICAL COUNCIL ACT, 1956

INSTRUCTION:

A. Please fill up the form in capital letters and attach supporting documents.
B. PART 1: Particulars of the Applicant
C. PART 2: Proposed Medical Institution Details
D. PART 3: Hospital Details

PART 1. PARTICULARS OF THE APPLICANT

1. Constitution of the Applicant:

☐ Society registered under the Societies Registration Act, 1860 (21 of 1860) or Corresponding Acts in States

☐ A public religious or charitable trust registered under the Trust Act, 1882 (2 of 1882) or the WAKFS Act, 1954 (29 of 1954)

☐ Company registered under the Companies Act, 1956

☐ An autonomous body promoted by State/Central Govt. or under a statute for the purpose of medical education.

2. Whether medical education is one of the objectives of the applicant in case the applicant is an autonomous body, registered society, charitable trust & company registered under Companies Act

☐ Yes

☐ No

3. Name of the Applicant (Autonomous body / Registered society / Charitable trust / Company registered under Companies Act)

4. Registration Number, PAN & Country / State where registered (Please attach registration document):

Registration No.													
Country													
State													
PAN No.													

5. Registered Address of the Applicant (Autonomous body / Registered society / Charitable trust / Company registered under Companies Act)

CITY																	
STATE																	
COUNTRY																	
PIN CODE																	
TELEPHONE																	
FAX																	

6. Particulars of the Head of the Proposed Medical Institution and Existing Hospital:

   a. Details of the Head of the Proposed Medical Institution

      i. Name : _____
      ii. Qualification : _____
      iii. Experience : _____
      iv. Contact No : _____
      v. Email Id : _____

   b. Details of the Head of the Existing Hospital

      i. Name : _____
      ii. Qualification : _____
      iii. Experience : _____
      iv. Contact No : _____

v. Email Id : _____

7. Financial Details

Financial Year	Annual Turnover (in lakh)	Net Worth (in lakh)	ITR Ackn. No.

8. Source of Current Finances: (In Percentage)

a) Contribution of the Applicant : _____
b) Grants : _____
c) Donations : _____
d) Equity : _____
e) Term loans : _____
f) Other sources (if any) : _____

9. Revenue Assumptions

a) Courses Applied For
b) Proposed annual intake of students
c) Fee structure
d) Estimated annual revenue from various sources

10. Expenditure Assumptions

a) Operating expenses
b) Depreciation

PART 2. PROPOSED MEDICAL INSTITUTION DETAILS

11. Name of Proposed Medical Institution:

12. Address of Proposed Medical Institution:

CITY																	
STATE																	
COUNTRY																	
PINCODE																	
TELEPHONE																	
FAX																	

13. Comment on the need for increase in medical manpower & how the existing medical facilities will get augmented by the establishment of proposed medical Institution):

14. Site Characteristics and Availability of External Linkages.

(a) Plot size : _____

(b) Constructed Area (In Sq. Ft.) : _____

(c) Road access : _____

(d) Availability of public transport : _____

(e) Electric supply : _____

(f) Water supply : _____

(g) Sewage connection : _____

(h) Communication facilities : _____

15. Educational Proposal

(a) Courses Applied For
(b) Proposed annual intake of students
(c) Admission criteria
(d) Method of admission
(e) Reservation/preferential allocation of seats.

PART 3. HOSPITAL DETAILS

16. Details of Hospital:

a) Bed strength
b) Bed distribution & Bed occupancy
c) Whether the norm of 5 in patients per student would be fulfilled.
d) Clinical and Para Clinical Departments
e) OPDs and Average OPD attendance department wise.
f) Hospital services, administrative services and other support services

17. Equipment Details: List of Medical / Allied Equipments

(a) Modern Medicine (Department Wise)

(b) Homeopathy (if available)

(c) Ayurveda (if available)

(d) Naturopathy (if available)

(e) Physiotherapy (if available)

18. Man power details: Department wise and year wise requirements of:

(a) Medical Staff (Department Wise)

(b) Para Medical Staff

(c) Other staff

19. Built up area of:

(a) Hospital

(b) Faculty, Staff & Students Housing (If any)

(c) Administrative office

DECLARATION:

I declare that all the information given in the applications form is true to the best of my knowledge & belief and that if found guilty i shall be liable to any action by the University including the cancellation of collaboration now or in future.

Signature : _____

Name of Authorized Signatory : _____

Designation of the Applicant : _____

Contact No : _____

E-Mail Id : _____

Seal of the Hospital :

LIST OF ENCLOSURES:

1. Certified copy of Bye Laws/Memorandum and Articles of Association/ Trust deed.
2. Certified copy of Certificate of registration/incorporation.
3. Annual reports and Audited Balance sheets for the last three years
4. Proof of ownership of existing hospital
5. Other enclosures as per the various parts of applications. (Please indicate details).