FORM 12

APPLICATION FOR REGISTRATION OF HOSPITAL TO CARRY OUT ORGAN OR TISSUE TRANSPLANTATION OTHER THAN CORNEA

(To be filled by head of the institution)

(Refer rule 24(1))

To

The Appropriate Authority for organ transplantation……..……...……...
(State or Union territory)

We hereby apply to be registered as an institution to carry out organ/tissue transplantation.

Name(s) of organ (s) or tissue (s) for which registration is required……..……...

The required data about the facilities available in the hospital are as follows:-

(A) HOSPITAL:

1. Name:
2. Location:
3. Government/Private:
4. Teaching/Non-teaching:
5. Approached by:

Road:	Yes	No
Rail:	Yes	No
Air:	Yes	No

6 Total bed strength:
7 Name of the disciplines in the hospital:
8 Annual budget:
9 Patient turn-over/year:

(B) SURGICAL FACILITIES:

1. No. of beds:
2. No. of permanent staff members with their designation:
3. No. of temporary staff with their designation:
4. No. of operations done per year:
5. Trained persons available for transplantation
   (Please specify Organ for transplantation)

(C) MEDICAL FACILITIES:

1. No. of beds:
2. No. of permanent staff members with their designation:
3. No. of temporary staff members with their designation:
4. Patient turnover per year:
5. Trained persons available for transplantation
   (Please specify Organ for transplantation):
6. No. of potential transplant candidates admitted per year:

(D) ANAESTHESIOLOGY:

1. No. of permanent staff members with their designations:
2. No. of temporary staff members with their designations:
3. Name and No. of operations performed:
4. Name and No. of equipments available:
5. Total No. of operation theatres in the hospital:
6. No. of emergency operation-theatres:
7. No. of separate transplant operation theatre:

(E) I.C.U./H.D.U. FACILITIES:

1. I.C.U./H.D.U. facilities: Present…… Not present……..……
2. No. of I.C.U. and H.D.U. beds:
3. Trained:-
   Nurses:
   Technicians:
4. Name of equipment in I.C.U.

(F) OTHER SUPPORTIVE FACILITIES:

Data about facilities available in the hospital:

(F1) LABORATORY FACILITIES:

1. No. of permanent staff with their-designations:
2. No. of temporary staff with their designations:
3. Names of the investigations carried out in the Department:
4. Name and number of equipments available:

(F2) IMAGING FACILITIES:

1. No. of permanent staff with their-designations:
2. No. of temporary staff with their designations:
3. Names of the investigations carried out in the Department:
4. Name and number of equipments available:

(F3) HAEMATOLOGY FACILITIES:

1. No. of permanent staff with their-designations:
2. No. of temporary staff with their designations:
3. Names of the investigations carried out in the Department:
4. Name and number of equipments available:

(F4) BLOOD BANK FACILITIES (Inhouse or access): Yes …… No……..……

(F5) DIALYSIS FACILITIES: Yes …… No……..……

(F6) Transplant coordinators (Eye Donation Counselors, in case of Cornea Transplantation):

Yes No

Number Posted:
Number Trained:

(F7) OTHER SUPPORTIVE EXPERT PERSONNEL:

1.	Nephrologist	Yes/No
2.	Neurologist	Yes/No
3.	Neuro-Surgeon	Yes/No
4.	Urologist	Yes/No
5.	G.I. Surgeon	Yes/No
6.	Paediatrician	Yes/No
7.	Physiotherapist	Yes/No
8.	Social Worker	Yes/No
9.	Immunologists	Yes/No
10.	Cardiologist	Yes/No
11.	Respiratory physician	Yes/No
12.	Others…….	Yes/No

The above said information is true to the best of my knowledge and I have no objection to any scrutiny of our facility by authorised personnel. A Bank Daft/cheque of Rs. 10000/ (for new registration) and Rs. 5000 (for renewal) in favour of……..is enclosed.

Sd/-
HEAD OF THE INSTITUTION