F O R M - 11

APPLICATION FOR REGISTRATION OF HOSPITAL TO CARRY OUT ORGAN TRANSPLANTATION

To

The Appropriate Authority for organ transplantation_____

(State or Union Territory)

We hereby apply to be recognized as an institution to carry out organ transplantation. The required data about the facilities available in the hospital are as follows

A) Hospital

1. Name _____
2. Location _____
3. Govt./Pvt. _____
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 hospitals _____
8. Annual Budget _____
9. Patient turnover/year _____

B) Surgical Team

1. No. of beds _____
2. No. of permanent staff with their designation _____
3. No. of temporary staff _____
4. No. of operations done per year _____

5. Trained persons available
for transplantation (Please specify
organ for transplantation) _____

C) Medical Team

1. No. of beds _____
2. No. of permanent staff
with their designation _____
3. No. of temporary staff _____
4. Patient turnover per year _____
5. No. of potential transplant
candidates admitted per year _____

D) Anaesthesiology

1. No. of permanent staff
members with their
designation _____

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 the emergency
operation-theatres _____

7. No. of separate transplant
operation theatre _____

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

1. ICU/HDU facilities : Present_____Not present_____
2. No. of ICU beds _____
3. Trained _____
   Nurses _____
   Technicians _____
4. Name and number of equipments in ICU _____

(F) Other Supportive Facilities :

Data about facilities available in the hospital.

(G) Laboratory facilities

1. No. of permanent staff with their designations.
2. No. of temporary staff with their designations.
3. Name of the investigations carried out in the Deptt.
4. Name and No. of equipments available.

(H) Imaging Services:

1. No. of permanent staff with their designations.
2. No. of temporary staff with their designations.
3. Name of the investigations carried out in the Deptt.
4. Name and No. of equipments available.

(I) Haematology Services:

1. No. of permanent staff with their designations.
2. No. of temporary staff with their designations.
3. Name of the investigations carried out in the Deptt.
4. Name and No. of equipments available.

(J) Blood Bank Facilities : Yes_____ No_____

(K) Dialysis Facilities : Yes_____ No_____

(L) Other 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

The above said information is true to best of my knowledge and I have no objection to any scrutiny of our facility by authorized personnel. A Bank Draft/Cheque of Rs. 1,000/- is being enclosed.

Head of the Institution