Ahmedabad Hospitals & Nursing Homes Association

Membership Registration Form

Form **01**

Filling up of this form & submission to AHNHA does not entitle you for a membership of AHNHA automatically. This form will be scrutinized & reviewed by the executive committee and final decision will be conveyed to you.

PLEASE FILL IN BLOCK LETTERS

For Office Use

A. DETAILS OF HOSPITAL / NURSING HOME

Category ☐ Zone ☐

Name of the Hospital / Nursing Home : _____

Address of the Hospital / Nursing Home : _____

_____ Area : _____ Pin Code : _____

Mobile : (1) _____ (2) _____

Landline : (1) _____ (2) _____

E-mail ID : _____ Website : _____

AMC Reg. No. / Local Municipal Authority Reg. No. : _____

Established in Year : _____

B. DETAILS OF OWNERSHIP

Name of the Owner / Directors / Partners : _____

(In case of company, write company's name)

Name	Designation	Address	Mobile & E-mail

Registered Address of the Company : _____

_____

Name of the Representative : _____ Mo. : _____

Designation of the Representative : _____ E-mail : _____

Name of the Doctor in whose name AMC registration is done : _____ MCI Reg. No. _____

Address : _____

_____ E-mail : _____ Mobile : _____

Name of the In-charge of the hospital / Nursing home : _____

Name of the CEO / COO / MD : _____

C. DETAILS OF DOCTORS

(1) Full Time :

	Name	Specialty	Registration No.
(1)			
(2)			
(3)			
(4)			
(5)			

(Please attach sheet if required)

(2) Part Time :

	Name	Specialty	Registration No.
(1)			
(2)			
(3)			
(4)			
(5)			

(Please attach sheet if required)

D. DETAILS OF FACILITIES OF HOSPITAL / NURSING HOME

(1) No. of Beds : _____ (Exclude Beds of Emergency, Dialysis, Day Care)

(2) No. of Emergency Beds : _____ (3) No. of Day Care Beds : _____

(4) Specialty Treatments Offered (Mentation only Key Specialities)

_____ _____

_____ _____

_____ _____

E. PHYSICAL INFRASTRUCTURE

☐ Independent Building ☐ Part of Commercial Complex

(1) No of Operation Theaters : _____ (2) No of Critical Care Beds : _____

Total :

(3) Intensive Care Unit Beds : _____ (4) Intensive Cardiac Care Unit Beds : _____

(5) Surgical Intensive Care Unit Beds : _____ (6) CT SICU Beds : _____

(7) Neurosciences ICU Beds: _____ (8) Other : _____

F. EQUIPMENTS : (OPTIONAL)

☐ CT Scan ☐ Linear Accelerator ☐ MRI ☐ PET CT

_____ _____

_____ _____

_____ _____

G. STAFF DETAILS

- Total Staff : _____
- Administrative : _____

Clinical :

- Doctors : _____
- Nurses : _____
- Paramedical : _____

Support :

- Housekeeping : _____
- Attendant : _____
- Security : _____
- Cafeteria : _____

Date : _____ Name : _____

Time : _____ Sign. _____

Fees to be Paid : _____

For Office Use : Category _____ Zone _____

(A) Form Received on : _____ By : _____

Fees Amount : _____ Paid on : _____ By Cash / Cheque / NEFT / Others _____

Payment Bank : _____ Receipt given on : _____

(B) Membership approved by executive committee on : _____ MOM No. : _____

Sign. of president / Secretary : _____