

FORM 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 hospital
8. Annualbudget
9. Patient turnover / year

B. Surgical Team

1. No. ofbeds
2. No. of permanent staff members with their designations.
.....
3. No. of temporary staff with their designations
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 members with their designations
.....
3. No. of temporary staff members with their designations.
.....
4. Patient turnover per year
5. 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 theatres
- 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. Names 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. Names 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. Names 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 the 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