



SCL PARAMEDICAL COUNCIL OF INDIA

APPLICATION FORM FOR OPENING A NEW PARA-MEDICAL PROGRAMME

1. Name of the Institution/Trust/NGO etc: _____
2. Name of the Owner/Director : _____
3. Address of the Institution : _____

(IN CAPITAL LETTER)

- i. District : _____ pin : _____
 - ii. Contact No: _____ fax no : _____
 - iii. Email id : _____
4. Year of Establishment : _____
 5. Whether the Institute is :
 - a) Government :
 - b) University :
 - c) Private :
 6. Phone : _____
 7. Email id : _____
 8. Affiliated to/Registered By (university/any other body) : _____
 9. Name of the affiliating body : _____
 10. Postal address : _____
 11. Phone/FAX/email : _____
 12. A copy of Essentiality certificate of State Government If [Yes] [No] (Documents to be Attached) :
 - a) Registration Certificate of the Institution/ Home Department
 - b) List of Management Members & Address
 - c) No Objection Certificate (NOC) from State Government
(Govt. Order No. & Date : _____ Date _____)
 - d) Strength & details of Teaching Faculties with their bio-data
 - e) Details of Regents availability
 - f) Land Patta
 13. **Physical Facilities**

1. Whether the institution has own: 1. Yes 2. No
Building. If yes, Blue Print/Certificate : Annexure _____
to be attached

2. No. of Class Rooms : _____
3. No. of Labs ,infrastructure Details : _____
4. Library Facilities : _____
5. Computer Lab : _____
6. Auditorium : _____
7. Office Facilities : _____

14. Clinical Facilities

1. Name of the Parent Hospital, if any : _____
 No. of Beds : _____
 Pollution control board certificate : Annexure _____
 to be attached
2. Name of the Affiliated Hospital, if any : _____
 No. of Beds : _____
 Pollution control board certificate : Annexure _____
 to be attached

15. Teaching Facilities

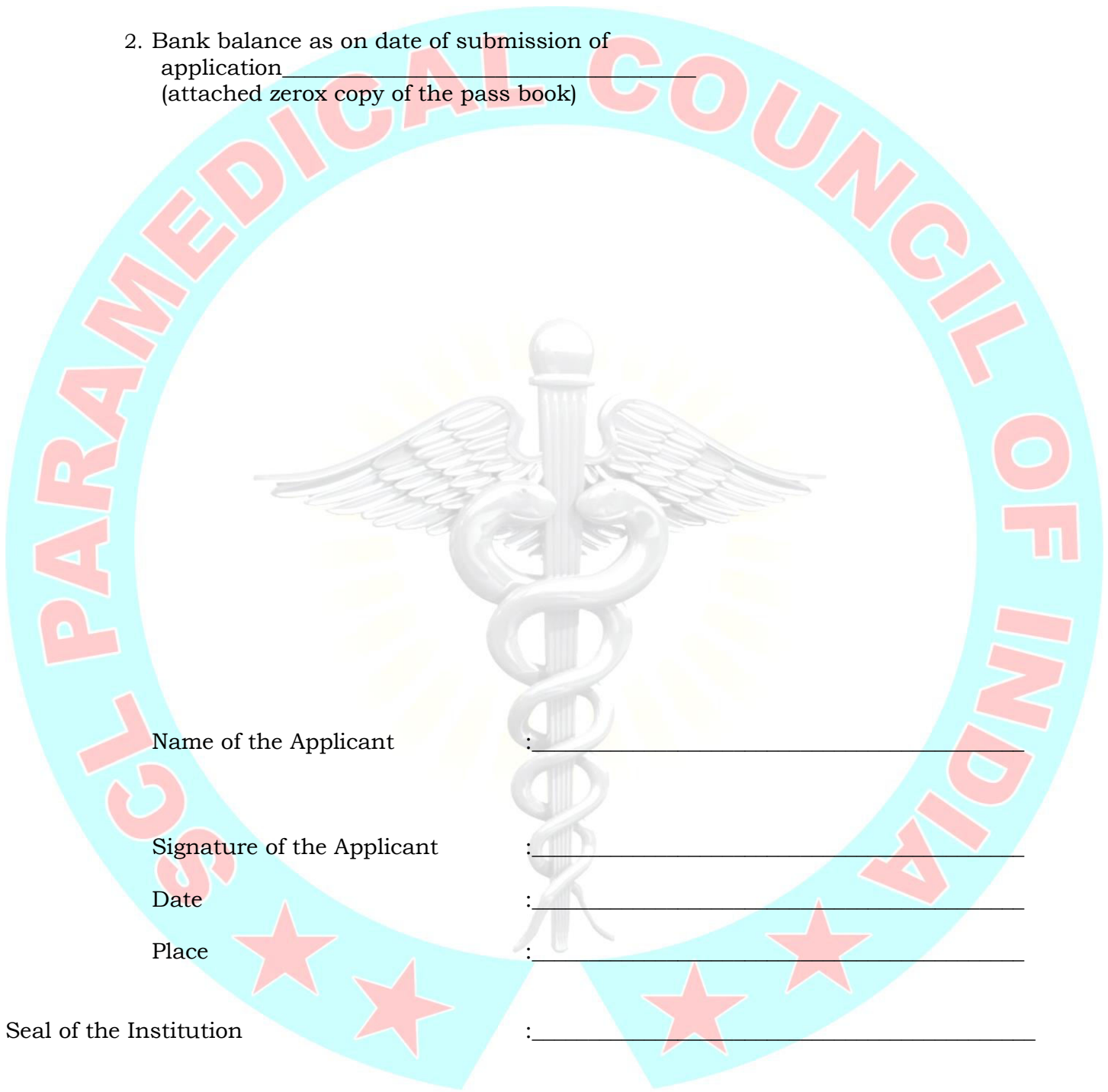
Sl.No	Name of teaching faculty	Designation	Qualification	Name of the Instt./Uty.	Year of Passing	R.N. & R.M. No.	Teaching Exp.	Date of Joining

16. Financial Details:

1. Budget allocated to Para-medical programme :

(Last year audited expenditure to be enclosed : Annexure

2. Bank balance as on date of submission of application _____
(attached zerox copy of the pass book)



Name of the Applicant : _____

Signature of the Applicant : _____

Date : _____

Place : _____

Seal of the Institution : _____

DECLARATION BY THE APPLICANT

I.....S/o, D/o or W/o.....
declare that all the documents & information submitted in this application form are true and best of my knowledge. I understand that if any of the information is found wrong, my application will Stand cancelled. I will abide by the rules & regulations in force in Para-medical Council India and as Amended from time to time.

Name of the Applicant : _____

Signature of the Applicant : _____

Date : _____

Place : _____

Seal of the Institution : _____

