PARAMEDICAL WING

INDIAN MEDICAL ASSOCIATION - TAMIL NADU STATE BRANCH

(Authorization Form for conducting Diploma in Hospital Nursing Course / Diploma in Health Assistance Course / Diploma in O.T. Technician Course / Diploma in Hospital Administration / Diploma in Diagnostic Technician Course)

Separate application form for each Course

AUTHORIZATION APPLICATION FORM (Please write in Capital)

1. Name of the Course :
2. Name of the Hospital / Institution
3. Address of the Hospital / Institution

   Office Telephone : STD Code : Fax :
   E.mail : Mobile
4. IMA NHB Number
5. Chairman / Head of the Institution
6. IMA Life Membership Number : Branch :
7. Managing Director / Administrator
8. IMA Life Membership Number : Branch :
9. Whether proprietorship / Private Limited / Public Limited / any other _____
10. Address of the functioning Centre

    Office Telephone : STD Code : Fax :
    E.mail : Mobile
11. Address of the Administrative Centre

    Office Telephone : STD Code : Fax :
    E.mail : Mobile
12. Number of Beds
13. Census in the past 3 years

Year	OP	IP	Labour

14. Laboratory facilities
    Clinical Pathology : Y / N Microbiology : Y / N Biochemical : Y / N Blood Bank : Y / N
15. Equipment availability
    No. Microscope _____ / Auto Analyzer : Y / N Semi Auto Analyzers Y / N Flame Photometer : Y / N
    Elisa Reader : Y / N Cell Counter : Y / N ABG Machine : Y / N Any other _____
16. Operation Theatre :
    No. of OT Major _____, Minor _____, Labour _____, Septic _____
    No. of Boyles _____ Autoclave _____ C-arm _____ Laparoscope _____ Any other _____
    Surgeries performed in last 3 years _____ _____ _____

If above facilities are not available provide a copy of memorandum of understanding with tip up centre / unit with their facilities.

17. Mode of Payment (Demand draft in favour of IMA Paramedical Wing, payable at Chennai).
    Rs. _____ Demand Draft No. _____ dated _____ Bank _____

I promise to abide by the rules and regulation of IMA TNSB to be passed as and when necessary by Paramedical Wing for administration and by College of General Practitioners for Education & training Purpose.

All the information provided is to be best of my knowledge.

Date : Seal : Hospital / Institution Signature