Ahmedabad Hospitals & Nursing Homes Association

Membership Registration Form

Form **01**

Filling up of this form & submission to AHNA 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 : _____

CEA No. : _____ Established in Year : _____

No. of beds as per CEA registration : _____

B. DETAILS OF OWNERSHIP

Name of the Owners / 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 additional 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. DETAILS OF OTHER BRANCHES OF YOUR HOSPITAL

	Name	Address	Area	Contact No.	Email Id
1)					
2)					
3)					

Date : _____ Time : _____

Fees to be Paid : _____

For Office Use : Category ☐ Zone ☐

(A) Form Received on : _____ By : _____

Fees Calculation : 1) Joining Fees : _____

2) Annual Fees / Life Time Fees : _____

Total Fees : _____

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

Name of Bank : _____ Receipt No.: _____ Given on: _____

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

Sign. of President / Secretary : _____