

FORM NO.3F
[See rule 52 O (1)]

APPLICATION FOR ISSUE/RENEWAL OF CERTIFICATE OF RECOGNITION AS RECOGNISED MEDICAL INSTITUTION

1	Name and complete postal address of the institution with telephone number, facsimile number and e-mail ID (relevant supporting documents to be submitted)	:	
2	Name of the Head/ In-charge of the Institution	:	
3	Number of persons employed i. Doctors ii. Nursing Staff iii. Others	:	Doctors : Nursing Staff : Others :
4	Number of patients treated during the previous calendar year i. In Patients ii. Out patients iii. Home care	:	In Patients : Out patients : Home care :
5	Name(s) of the qualified medical practitioner (s) who would prescribe essential narcotic drugs (give details of their training in pain relief and palliative care or opioid dependence treatment)	:	
6	If there is more than one qualified medical Practitioner who would prescribe essential narcotic drugs, indicate the name of the medical Practitioner who shall be overall in charge	:	
7	Number and date of the certificate of recognition issued earlier (attach copy)	:	
8	Whether the recognition of the institution was withdrawn earlier (if the recognition was withdrawn earlier, the details are to be given)	:	

Date:

Signature:

Place:

Full Name:

Seal:

Designation: