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 practtioner (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 practioner who would prescribe essential narcotic drugs,indicate the name of the medical practioner 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8	Whether the recognition of the institution was withdrawn earlier(if the recognition was withdrawn earlier, the details are to be given)	:	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: