

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

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

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| 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 | : | |
| 4. | Number of patients treated during the previous calendar year (i) in patients (ii) out patients (iii) home care | : | |
| 5. | Name (s) of the qualified medical practitioner (s) who would prescribe Essential narcotic drugs give detail 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 | Whether the recognition of the institution was withdrawn earlier (if the Recognition was withdrawn earlier, the details are to be given) | : | |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:

Position: