

DIPS India

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Application for Affiliation of Paramedical Institution

Proposed Information for Paramedical Institution Profile:

1.	Name of Institutions:	
2.	Type of Institution: (Tick on appropriate option) Kindly enclose attested Deeds, Memorandum and Rules/Regulations (as applicable)	Trust Society Co-operative society Limited Company Private Limited Company Firms/Partnership Firms Others
3.	Name of the Trust/Society/Company running the institution:	
4.	Date and Number of Registration of Trust/ Society/Company (Please attach proof):	
5.	Postal Address of Institution:	
6.	Communication Details:	
	STD Code:	
	Contact Number:	
	Fax Number:	
	Mobile Number:	
	E-mail Address:	
	Website Address:	
7.	Pan Number of Institution: (Kindly enclose the copy)	
8.	Audited Balance Sheet of past three years; if not enclosed, reasons for non inclusion	
9.	Document relating to address proof of the Institution (Leave Deed/Rent Agreement/ Sale Deed/Ownership Document)	
10.	Floor Plan/Layout Map of Institution:	
11.	Photograph of Institution, Reception , Counseling Room, Computer Lab, Classroom, Lab Area. (measurement also)	

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Details of Management/Head of Institution

Name of Head of Management/ Co- Coordinator:		Affix recent Colored photograph duly self-attested
Designation:		
Postal Address:		
Communications Connectivity of: STD Code: Contact Number: Fax Number: Mobile Number: Residence Number: Email Address:		
Personal details of Head of Management:		
Educational Qualification: (Kindly Enclose the copy)		
Profession & Experience: (Kindly enclose the detailed of Biodata)		
Photo ID Proof: (Kindly Enclose the copy)		
PAN Number: (Kindly Enclose the copy)		

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list of Healthcare Experts:(Minimum Medical Graduate in concern stream):

Note:

Kindly enclose detailed Bio Data and self-attested copies of educational certificates of the faculties. The council may insist on meeting any / all faculty member and / or inspection of their appointment / contact / engagement orders. Please use a separate sheet if required.

Name	Qualification	Experience	Mobile No.

Infrastructural Facilities

1. Location of Proposed Institution Area: (Kindly tick whichever is applicable)	<input type="checkbox"/> Metro <input type="checkbox"/> State Capital <input type="checkbox"/> District Headquarter <input type="checkbox"/> Town. <input type="checkbox"/> Rural
2. The building of Institution is: (Kindly tick whichever is applicable and furnish the documents)	<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Lease <input type="checkbox"/> Other
3. Total Carpet Area of Institution (In Sq.Ft.):	
4. Total Site Area of Institution (In Sq. Ft.):	
5. Type of Flooring Institution:	

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Institution Facilities Available:

Sr. No.	Type of Facility	No. of Rooms	Area (in Sq. Ft.)	Seating Capacity
1.	Counselling Room (Minimum 1 Room Requirement)			
2.	Classrooms (Minimum 2 Rooms Each 300Sq. Ft. Requirement)			
3.	Library (Minimum 1 Room 200Sq. Ft. Requirement)			
4.	Laboratory (Minimum 1 Room 500Sq. Ft. Requirement)			
5.	Conference Room (Minimum 1 Room 200Sq. Ft. Requirement)			
6.	Staff Room (Minimum 1Room Requirement)			
7.	Council ng Area (Minimum 100Sq. Ft. Requirement)			
8.	Computer Laboratory (Minimum 1 Room 200Sq. Ft. Requirement)			

Facilities For Practical /Internships /OJT Venue

1.	Name of Associate Institute/ Firms/Company Hospital. Where practical/ Internship training will be provided (Kindly enclose a copy MOU for practical)	
2.	Complete Address of Associate Institute/Firms/Company/Hospital. Where practical training will be provided	

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DECLARATION

I / We certify that all the information given above and in the preceding pages signed by me / us is / are complete and correct.

I / We declare that the institute will abide by all the rules and regulations /directions of COUNCIL given time to time.

I / We declare that I / We am / are authorized to sign on behalf of my organization and that my directors and shareholders / members (where relevant) are in total agreement with my / our application.

In case any information furnished by me / us is found wrong or incomplete, I / We declare that the institute may be derecognized and is also open to any action as per law.

I / We undertake not to do any advertisement of our own in print / electronic media without the prior written permission of Allied Health and Management Council, New Delhi.

I / We hereby undertake that if it is ever found that the Institution is not able to run as per the norms, rules and procedures laid down by the COUNCIL. The ALLIED HEALTH AND MANAGEMENT COUNCIL, NEW DELHI shall be free to withdraw the affiliation of Centre Permission.

I / We understand that the ALLIED HEALTH AND MANAGEMENT COUNCIL, NEW DELHI reserves the right to terminate the affiliation of Centre Permission Centre code if it is found that I / We have knowingly made a false declaration in the form.

I / We understand that the approval of my / our institution as Affiliation of Paramedical Centre shall be done as per the norms of the COUNCIL.

I / We understand that ALLIED HEALTH AND MANAGEMENT COUNCIL, NEW DELHI reserve the right to reject the application without assigning any reason.

I / We understand that the Affiliation of Paramedical Institute is approved for one year only, subject to subsequent renewal on the sole discretion of the COUNCIL.

Place:

Date: Head of the Institution Signature, Name and Seal

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SELF DECLARATION FORM

(To be typed in Rs. 100/- Indian Non-judicial stamp Paper)

I/We hereby apply for my/our Affiliation of Paramedical Institute for session of Allied Health and Management Council, New Delhi

To pay all the fees as per the COUNCIL Norms.

Not to charge any extra fees from the trainees apart from the fees prescribed by the COUNCIL in the prospectus / website.

To have the format of my/our advertisements approved by the COUNCIL before I/We release it to the media.

To submit all the hard copy of applications along with to the COUNCIL within the prescribed time limit.

To deliver counseling /information's / admission / training services as per the norms of the COUNCIL.

To individually verify all the documents enclosed with the trainee forms with the originals.

To take full responsibility for all the documents/correspondence signed by my staff on my behalf.

To abide by all the rules and regulations of the COUNCIL as promulgated from time to time.

Not to indulge in any sort of criminal/immoral/illegal activities.

I understand that the Affiliation of Paramedical Institute sanction is for one year only, or expiry of MOU subject to subsequent renewal as per the COUNCIL norms.

I/We further acknowledge that if at any point of time the COUNCIL finds any deficiency in my/our infrastructure or in the support services to the trainees or if I/we am/are found involved in any sort of unlawful activities, then the COUNCIL will have the full right to terminate my/our Affiliation of Paramedical Institute authorization without seeking any my/our clarification.

Signature of the Centre's Director
(with Seal & Date)

Attested by Notary
(with Seal/ Stamp & Date)