



FORM B

Application for Registration under Section 5 of the Maharashtra (Mumbai)  
Nursing Homes Registration Act, 1949.

खुण केलेले रकाने भरणे आवश्यक आहे / Fields Marked with \* are Mandatory Fields

Old Registration Entry *	:	<input type="radio"/> Yes <input type="radio"/> No
Registration Number *	:	
Date of Registration *	:	
Ward No. *	:	
Valid From *	:	
Valid Till *	:	
Registration Fees (Rs.)	:	

Name of Applicant	:	
-------------------	---	--

Permanent Residence of Applicant			
House No		House Name *	
Street 1 *		Street 2	
Area 1 *		Area 2	
City *	MUMBAI	Pin Code	
Country *		State *	Maharashtra
Telephone (Off.)		Telephone (Res.)	
Mobile No.		E-Mail Address	

Ward *	:	
Qualifications *	:	
Nationality *	:	(Specify, if Other)

Situation of the Registered or Principal Office of the Company Society, Association or other body Corporate			
House No		House Name	
Street 1 *		Street 2	



Area 1 *		Area 2	
City *	MUMBAI	Pin Code	
Country *	India	State *	Maharashtra
Telephone (Off.)		Telephone (Res.)	
Mobile No.		E-Mail Address	

(a).	Name of the Nursing Home in Respect of which the Registration is Applied for *	:	
7(b).	Other Particulars of the Nursing Home in Respect of which the Registration is Applied for *	:	

Place where the Nursing Home is situated			
House No.		House Name *	
Street 1 *		Street 2	
Area 1 *		Area 2	
City *	MUMBAI	Pin Code	
Country *		State *	Maharashtra
Telephone (Off.)		Telephone (Res.)	
Mobile No.		E-Mail Address	

9.	Brief Description of the Construction size and Equipment of the Nursing Home or any Premises used in connection therewith *	:	
10.	Whether Nursing Home or any Premises used in connection therewith are used or are to be used for purpose other than that of carrying on Nursing Home	:	Yes <input type="checkbox"/> No <input type="checkbox"/>
11(a).	Number of Beds for Maternity Patients *	:	
11(b).	Number of Beds for Other Patients *	:	
12.	Place where the Nursing Staff is accommodated *	:	
13.	No. of Members of the Nursing Staff in the Nursing Home. *	:	
14.	No. of Resident or Visiting Physicians / Surgeons in Nursing Home. *	:	



15(a)	Whether the Nursing Home is under the Supervision of a Qualified Medical Practitioner or a Qualified Nurse. *	<input type="radio"/> Yes <input type="radio"/> No
-------	---	--

If Yes, Name of Person					
	Title *	First Name *	Middle Name	Last Name	
Age (Years) *					
Qualification *					

15(b)	Proportion of the Qualified and Non-qualified Nurses on the Nursing Staff. *	
-------	--	--

16(a)	Whether the Nursing Home is under the Supervision of a Qualified Nurse or Midwife. *	<input type="radio"/> Yes <input type="radio"/> No
-------	--	--

If Yes, Name of Person					
Age (Years) *					
Qualification *					

16(b)	Whether any Unregistered Medical Practitioner or Unqualified Midwife is employed for Nursing any Patient in Nursing Home. *	<input type="radio"/> Yes <input type="radio"/> No
-------	---	--

17	Whether any Person of Alien Nationality is employed in the Nursing Home. *	<input type="radio"/> Yes <input type="radio"/> No
----	--	--

If Yes, Name of Person					
	Title *	First Name *	Middle Name	Last Name	
Age (Years) *					
Qualification *					

19	Whether the Applicant is interested in any other Nursing Home or Business. *	<input type="radio"/> Yes <input type="radio"/> No
----	--	--

If Yes, Place where such Nursing Home is Situated or where such Business is Carried.	
--	--

Date:  
Signature: