**Date of Application:**

**Applicant Organization Name:**

**Organization Primary Address:**

**Contact Person Name:**

**Contact Number:**

**Email Id:**

**Please mention your organizational activities:**

| **List of the Equipments***(Please attach details as Annexure A)* |  |
| --- | --- |
| **Site Specific List of Equipments** *(Please attach details as Annexure B)* |  |

| **S.No** | **District** | **Name of the Hospital** | **Medical device Name** | **manufacturer** | **Model Name** | **Sr. No.** | **Functional State(Active/Non-active)** | **Dept.** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |

Authorized Signatory Name: Signature & Date with stamp: