**Application Form for Healthcare Textiles Processing Facility Certification scheme**

All fields should be filled correctly

Healthcare facility: Hospital Nursing homes 

Extended care facilities, standalone surgical centers, clinics, medical, surgical, and dental facilities 

| 1. **Organization/Company details** | | | | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Company Name (Legal entity requiring certification): | | | | | | | | | | | | | | | | | | | | | |
| Site-1 Address (to be certified): | | | | | | | | | | Please detail the processes and Activities at site-1 | | | | | | | | | | | |
| Postcode: | | | | State: | | | | | | | | Country: | | | | | | | | | |
| **If more than one site is to be certified, specify the other site address**  **☐YES ☐NO** | | | Site-2 address | | | | | | | | Site-3 address | | | | | | | | Site-4 address | | |
|  | | | | | | | |  | | | | | | | |  | | |
| Postcode- | | | | | | | | Postcode- | | | | | | | | Postcode- | | |
| State- | | | | | | | | State- | | | | | | | | State- | | |
| Please detail the processes and Activities | | |  | | | | | | | |  | | | | | | | |  | | |
| E-mail: | | | | | | | | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | Fax: NA | | | | | | | | | | | | |
| Website: | | | | | | | | | | | | | | | | | | | | | |
| Chief Executive/MD: | | | | | | | | | | | | | | | | | Mobile: | | | | |
| Contact Person Name: | | | | | | | | Position:  Email: | | | | | | | | | | Mobile: | | | |
| Company Status (Please Tick)  Proof Document to be attached in Annex-1 (Company Registration or Certificate of Incorporation) | | | | | | | | ☐Public Limited | | | | | | | | | | | | | |
| ☐Private Limited | | | | | | | | | | | | | |
| ☐Partnership | | | | | | | | | | | | | |
| ☐Government | | | | | | | | | | | | | |
| ☐Proprietary | | | | | | | | | | | | | |
| ☐Limited Liability Partnership | | | | | | | | | | | | | |
| ☐Other (Please Specify): | | | | | | | | | | | | | |
| 1. **Did you use consultancy related to the Scheme?** | | | | | | | | | | | | ☐ NO  ☐ YES- please specify below | | | | | | | | | |
| Consultancy Company Name | | | | |  | | | | | | | | | | | | | | | | |
| Name of the Consultant | | | | |  | | | | | | | | | | | | | | | | |
| Extend and work performed | | | | |  | | | | | | | | | | | | | | | | |
| 1. **Does the organization have staff speaking in other than English and Hindi?** | | | | | | | | | | | | | | | ☐ NO  ☐ YES- please specify below | | | | | | |
| Other Languages | |  | | | | | | | | | | | | | | | | | | | |
| 1. **Are there any specific (relevant) legal obligations/regulatory approval/licenses related to the product, process and operations applicable for the organization?** | | | | | | | | | | | | | | ☐ NO  ☐ YES- please specify below and provide the related proof documents/certificates in Annex-3 | | | | | | | |
| License Number |  | | | | | | | | | | | | | | | | | | | | |
| Validity |  | | | | | | | | | | | | | | | | | | | | |
| 1. **Please describe the process activities and/or services of your company/hospital (for applied scope only)** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| 1. **Are you outsourcing any of the activities within the scope of certification?** | | | | | | | | | | | | ☐NO  ☐ YES- please specify below | | | | | | | | | |
| Overview of outsourced activities | | | | | | |  | | | | | | | | | | | | | | |
| 1. **A. Please provide details of the site-specific information for certification** | | | | | | | | | | | | | | | | | | | | | |
| Total number of Employees working | | | | | | Permanent:  Part-time: | | | | | | | Total number of shifts | | | | | | | |  |
| **Shift Details** | | | | | | Shift-1 | | | | | Shift-2 | | | | | Shift-3 | | | | Shift-4 | |
| Time | | | | | |  | | | | |  | | | | |  | | | |  | |
| Number of Staff | | | | | |  | | | | |  | | | | |  | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | |
| 1. Applicable Standards & Test Method if any: | | | | | | | | | | | | | | | | | | | | | |

**9. List of Equipment Details:**

| S.No | Equipment name | Manufacture | Model | Serial number | Functional & calibration status (Active/Inactive) | Department |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

\*Add more rows depending on the number of equipment’s or Attach separate the equipment list in the above format with the application form

**Declaration**

We hereby declare that the above-mentioned details are correct as per our knowledge. Also, we agree to pay the application processing fee and other fees charged for the services provided by KCS in time without any delay.

Name of Applicant:

Designation:

Signature & Company Seal:

**Annex-1**

**Proof for Company Registration or Certificate of Incorporation document**