

**FORM 13**  
**APPLICATION FOR REGISTRATION OF HOSPITAL TO CARRY OUT ORGAN/TISSUE RETRIEVAL**  
**OTHER THAN EYE/CORNEA RETRIEVAL**  
*(To be filled by head of the institution)*  
*(Refer rule 24(1))*

Note: Retrieval Hospitals may also be identified based on pre-defined criteria and registered as retrieval hospital by the appropriate authority.

To  
 The Appropriate Authority for organ transplantation.....  
 (State or Union territory)  
 We hereby apply to be registered as an institution to carry out organ/tissue retrieval.

The required data about the facilities available in the hospital are as follows:-

- (A) HOSPITAL:
- 1 Name:
  - 2 Location:
  - 3 Government/Private:
  - 4 Teaching/Non-teaching:
  - 5 Approached by:
 

Road:	Yes	No
Rail:	Yes	No
Air:	Yes	No
  - 6 Total bed strength:
  - 7 Name of the disciplines in the hospital:
  - 8 Annual budget:
  - 9 Patient turn-over/year:
- (B) SURGICAL FACILITIES:
1. No. of beds:
  2. No. of permanent staff members with their designation:
  3. No. of temporary staff with their designation:
  4. No. of operations done per year:
  5. Trained persons available for retrieval  
 (Please specify Organ and/or tissue for retrieval):
- (C) MEDICAL FACILITIES:
1. No. of beds:
  2. No. of permanent staff members with their designation:
  3. No. of temporary staff members with their designation:
  4. Patient turnover per year:
  5. Trained persons available for retrieval  
 (Please specify Organ and/or tissue for retrieval):
  6. No. of critical trauma cases admitted per year.
  7. No. of brain stem death declared per year.
- (D) ANAESTHESIOLOGY:
1. No. of permanent staff members with their designations:
  2. No. of temporary staff members with their designations:
  3. Name and No. of operations performed:
  4. Name and No. of equipments available:
  5. Total No. of operation theatres in the hospital:
  6. No. of emergency operation-theatres:
  7. No. of separate retrieval operation theatre:
- (E) I.C.U./H.D.U. FACILITIES:
1. I.C.U./H.D.U. facilities: Present..... Not present.....
  2. No. of I.C.U. and H.D.U. beds:
  3. Trained:-
 

Nurses:
Technicians:
  4. Name of equipment in I.C.U.
- (F) OTHER SUPPORTIVE FACILITIES:  
 Data about facilities available in the hospital:
- (F1) LABORATORY FACILITIES:
1. No. of permanent staff with their-designations:
  2. No. of temporary staff with their designations:

3. Names of the investigations carried out in the Deptt.:
4. Name and number of equipments available:

(F2) IMAGING FACILITIES:

1. No. of permanent staff with their-designations:
2. No. of temporary staff with their designations:
3. Names of the investigations carried out in the Deptt.:
4. Name and number of equipments available:

(F3) HAEMATOLOGY FACILITIES:

1. No. of permanent staff with their-designations:
2. No. of temporary staff with their designations:
3. Names of the investigations carried out in the Deptt.:
4. Name and number of equipments available:

(F4) BLOOD BANK FACILITIES: (in house or access)      Yes ..... No.....

(F5) Transplant coordinators:      Yes.....No.....  
Number Posted:  
Number Trained

The above said information is true to the best of my knowledge and I have no objection to any scrutiny of our facility by authorised personnel. I hereby give an undertaking that we shall make the facilities of the hospital including the retrieval team of the hospital available for retrieval of the organ/tissue as and when needed.

Sd/-  
HEAD OF THE INSTITUTION