

# Family Clinic Network Application Form

1. Name of the clinic : .....
2. Address : .....  
.....  
.....
3. City : .....
4. State : ..... Zip Code: .....
5. Contact Number : .....
6. Email Id : .....
7. Web site (If any) : .....
8. Speciality : .....
9. Years of Operation : .....
10. Accreditation or Certifications : ..... If yes specify  
.....
11. Registration Number : .....
12. Registration Valid Up to date : .....
13. Registering Authority : .....
14. Number of Beds (If any) : .....
15. Working Days : .....



16. Working hours : .....
17. PAN Number : .....
18. Number of Full-time doctors : .....
19. Number of consultants : .....
20. Total Number of Para Medics : .....
21. In house Laboratory : YES / NO
22. In House Pharmacy : YES / NO
- If yes Drug License Number : .....
23. Medical Record Department : YES / NO
24. Contact Person with Number : .....
- .....

**Declaration**

**I hereby wish to inform you that the information provided towards empanelment is true to the best of my knowledge. We understand the details and are interested in empaneling with Family Clinic Network**

**For Clinic, Name of the Signing Authority with Designation : .....**

**Signature with Date : .....**

