KERALA ENVIRO INFRASTRUCTURE LIMITED

INSIDE FACT (CD) CAMPUS
Ambalamedu P.O , PIN:682 303
Phone No:0484-2722141,241,341
CIN: 424129KL2005PLC017973
Email: rajesh.gopinathan@beil.co.in

CBWTF - AFFILIATION FORM FOR HEALTH CARE FACILITIES

Name of Health Care Facility			
Address-Permenant			
District		Pin Code	
Telephone		Fax	
Address-For Communication			
District		Pin Code	
Telephone		Fax	
Mobile		E-Mail	
Name of Person -In-Charge			
Medicl Council Reg. Number			
Telephone		Fax	
Mobile		E-Mail	
Bio-Medical Waste seggregation-in-charge			
Name			
Designation			
Qualification			
Mobile		E-Mail	
Working Time			
HCF- Category	Hospitals /Clinics /Nursing Homes /Medical College (Please Mark)		
HCF- Sub Category	Modern Medicine /Homeo /Ayurveda (Please Mark)		
Approved/Sanctioned Bed Strength			
a.) in all ICUs,		b.) Casuality	
c.) O.T.		d.) In-Patient	
e.) Covid Ward		f.) OPD	
g.) Number of Day Care Beds (If Any)			
Number of Blood Banks (if any)			
Number of Labs (If any)			
Number of Dental chairs			

Total Bed Strength (Sum of above)	
Please Mention if Any Additional Facilities	

Legal Documents (A copy to be attached along with affiliation form)			
PAN Card	Yes/No	PAN Number	
LSGD Registration Certificate	Yes/No	LSGD Reg. No.	
GST	Yes/No	GST Number	
PCB Consent	Yes/No	PCB Consent No.	
UTR / Payment Ref No			

Declaration:- I, Smt/Sri..... hereby declare that the information furnished above are correct and complete to the best of my knowledge. If at any time, during the period of affiliation with KEIL,any information is found incorrect concealed , exagerated or misleading, my affliation is liable to be cancelled.

Date: Signature of Authorised Person

Place Name of Authorised Person

….....

To be filled by KEIL

Affiliation Number			
Affiliation Date		Affiliation Valid Upto	
Verified Bed Strength		Other Facilities	
Affiliation Fee Remittance	Yes/No	Affiliation Fee	Rs….....
Remarks			
Verifying Officer Name		Signature	

APPROVED BY				
	Facility Head	**GM**	**CFO**	**CEO**
Name				
Signature				