FORM C

APPLICATION FOR CHANGE OF OWNERSHIP / NAME / ADDRESS of HCI affiliated to IMAGE

IMAGE Affiliation No. of the HCI _

No	Details	Existing	New (To be Changed)	Remarks (if any)
1.	Name and Address of Healthcare Institution			
2.	Name, Designation & Address of Owner of HCI			
3.	Type of Proof (*) submitted to change the ownership/ Name/ Address of HCI			
4.	Changes in facility if any			
5.	Land Phone. No. Mob. No. E mail Id.			

A. I declare that I have no objection in Changing the Name/ Ownership/ Address of the Institution as mentioned above.

Name (Present Owner): Signature:

B. I am fully aware of the Rules and Regulations of running a Health Care Institution including the Biomedical Waste Management Rules 2016 and ready to abide to the Terms & Conditions of IMAGE regarding the Biomedical Waste Management.

Name (New Owner): Signature:

Place: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _ _ (Office Seal)

(*) Sale Deed, Agreement / Any official Document to prove reason to Change Ownership/ Name/ Address of the Healthcare Institution