**APPLICATION FORM**

|  |  |
| --- | --- |
| Date of Application |  |
| Organization Name  |  |
| Registered Address |  | Postal Code |  |
| State |  |
| Country |  |
| **Contact Details** | Primary Details | Secondary Details |
| Name of the Person |  |  |
| Designation |  |  |
| Phone No. |  |  |
| Email Id |  |  |
| Website |  |
| No. of Sites |  |
| For AMC/CMC and OEM List of Hospital (for whom they provide service) with theirlocation details |  |
| Site 1 Address (Head Office) |  | Postal Code |  |
| State |  |
| Country |  |
| Site 2 Address  |  | Postal Code |  |
| State |  |
| Country |  |
| ***Add another Location by Insert Rows Below*** |
| Legal Status of Organization | Private |  | Public |  | Proprietorship |  | Partnership |  |
| Govt. Undertaken |  | PSU |  | LLP |  | Other \_\_\_\_\_\_\_\_\_ |  |
| Person responsible for Regulatory Compliance  | Name:Email: |
| GST Registration No. | For India Only |
| Where did you hear about us |  |
| How did you reach us? |  |
| Type of certification sought |     |
| Scope of Certification (e.g., departments, products, processes, Locations) |  |
| Existing Management Systems (e.g., ISO 9001, ISO 13485): |  |
| Documentation Status (e.g., policies, procedures, manuals): |  |
| **Biomedical Equipment Maintenance Practices** |
| Brief about Maintenance Process/Procedure |  |
| List of testing equipments present at the site with their calibration status. |  |
| Calibration and Testing Processes: |  |
| Training Programs for Technicians: |  |
| Planned Preventive maintenance Schedule for the present year. |  |
| Do you have Equipment’s evaluation process? |  |
| Emergency Maintenance Protocols: |  |
| **Personnel that contribute to BEMC Scheme** | **Number of the BEMC Scheme Effective Personnel** |
| Top Management |  |
| Management Representative(s) |  |
| Equipments Management Team |  |
| Competency criteria for personnel involved in Equipments maintenance  |  |
| Person(s) responsible for developing, implementing or maintaining Equipments performance improvements. |  |
| Person(s) responsible for significant Equipments uses |  |
| *Total Number of the BEMC Effective Personnel* |  |
| StageCertification status | Initial  | Surveillance No. \_\_\_\_\_\_\_\_\_\_ | Recertification  | For Transfer Case**Note:** Forward copy of latest audit report and current certificate |
| Certificate No:CB:AB: |
| If existing SIS Certification provided another standard other than this  | Accreditation BoardCertificate NoStandard(s) |  |
| **Additional Information Required**  |
| Dependency on outsourcing and suppliers including equipment services. | Little or no dependency on outsourcingSome dependency on outsourcing or suppliers, related to some but not all-important Equipment’s High dependencies on outsourcing or supplier, large impact on important Equipment’s activities. |
| Maintenance Agency & Personal Responsible (If any) |  |
|  |
| **Additional General Requirements** |
| Primary Language | English Hindi Other language ……………………………………………………… |
| Payment Method | Cheque Demand Draft NEFT or RTGS Others ………………………………… |
| Currency Used  | ₹ $ Others …………………………………………………………………………………. |
| Method of Correspondence | Email Fax Post Skype Phone call Others |
| **Declaration** |
| The above information is true to the best of my knowledge and belief, and I am authorized to provide such information on behalf of the company. I consent to the terms and conditions of the Biomedical Equipment Maintenance Certification (BEMC) Scheme and agree to comply with the certification requirements of SIS Cert. available on the website: **http://www.siscertifications.com.**Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Notes:**

The quotation will be based on the information provided in the quotation request form.

Please indicate your preferred target dates for the following activities:

* 1. Document Review (Specify Month/Year) ………………………...
	2. Preliminary Review (Specify Month/Year) ………………………
	3. Formal On-Site Review (Specify Month/Year) ……………………

The surveillance will be carried out on yearly basis.

 **For Hospitals, Annexure 1**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **District** | **Hospital name** | **Medical Equipment name** | **Manufacturer** | **Model** | **Serial number** | **Functional status (Active/Inactive)** | **Department** |
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\*Add more rows depending on the number of equipment

**For AMC/CMC Service Provider and OEM,**

 **Annexure 2**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sl. No.** | **Calibration Equipment Name** | **Manufacturer** | **Model** | **Calibration Due Date** |
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\*Add more rows depending on the number of equipment

|  |
| --- |
| **For Client Use** |
| **Name** |  |
| **Designation** |  |
| **Date** |  |
| **Application Review (For SIS Head Office Use Only)** |
| **Resource Allocation** |  |
| **Review Status** |  |
| **Quotation Generation** |  |

# SIS Certifications Pvt. Ltd.

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