

महाराष्ट्र शासन आरोग्य सेवा जिल्हा शल्यचिकित्सक, नांदेड (ग्रामीण रुग्णालय नियंत्रण कक्ष)	
कार्यालय क्र. : ०२४६२-२३४७५० वैयक्तीक (निवास) : ०२४६२-२३४३०५ फॅक्स : ०२४६२-२४५५१६	पत्ता : मेन रोड जिल्हाधिकारी कार्यालयाजवळ, वजीराबाद नांदेड पिन क्र. : ४३१६०१ ई-मेल : cs_nanded@rediffmail.com npcib.nanded@gmail.com
जा.क्र.जि.श.चि/रा.अ.निका/ 10687 /२५.	दिनांक : ०४ / ०९ / २०२५

प्रति,

मा.मुख्यकार्यकारी अधिकारी

जिल्हा परिषद नांदेड

विषय :-अशासकिय संस्थांना मोफत मोतिबिंदू शस्त्रक्रिया करणेसाठी
अर्ज मागविण्यासाठी जिल्हा परिषदेची वेबसाईट वापरणे बाबत.

संदर्भ :-या कार्यालयाची मंजुर टिपणी

महोदय,

उपरोक्त विषयास अनुसरून राष्ट्रीय अंधत्व नियंत्रण कार्यक्रम अंतर्गत मोफत मोतिबिंदू शस्त्रक्रिया करणेसाठी जिल्ह्यात कार्यरत अशासकिय संस्थाकडून अज वेबसाईटवर मागवायचे आहेत. त्यासाठी जिल्हा परिषदेची वेबसाईट zpnanded.in ही वापरावयाची आहे. त्यासाठी मान्यता मिळावी. ही नम्र विनंती.


 जिल्हा शल्यचिकित्सक,
 नांदेड

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Signature of Programme Authority

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<p>☎ : कार्यालय क्र. : ०२४६२-२३४७५० वैयक्तीक (निवास) : ०२४६२-२३४३०५ फॅक्स : ०२४६२-२४५५१६</p>	<p>पत्ता : मेन रोड जिल्हाधिकारी कार्यालयाजवळ, वजीराबाद नांदेड पिन क्र. : ४३१६०१ ई-मेल : cs_nanded@rediffmail.com npcb.nanded@gmail.com</p>
<p>जा.क्र.जिशचि/राअनिका/10685/२५.</p>	<p>दिनांक : ०८/०९/२०२५</p>

**राष्ट्रीय आरोग्य अभियान
राष्ट्रीय अंधत्व नियंत्रण व दृष्टीक्षिणता कार्यक्रम,
जिल्हा रुग्णालय, नांदेड**

राष्ट्रीय अंधत्व नियंत्रण कार्यक्रमांमध्ये मोफत मोतिबिंदू शस्त्रक्रिया करणे साठी सन २०२५-२६ मध्ये अशासकिय संस्था म्हणुन नियुक्ती करावयाची आहे. सदर अशासकिय संस्था म्हणुन मान्यता मिळणेसाठी आवश्यक ती सर्व माहिती नियम, अटी व अर्जाचा नमुना zpnanded.in या संगणकीय संकेतस्थळा वर प्रसिद्ध करणेत आलेला आहे, सदर अर्ज स्विकृतीचा कालावधी दि.०९.०९.२०२५ ते दिनांक १३.०९.२०२५ पर्यंत राहील.

ठिकाण : जिल्हा रुग्णालय नांदेड

(डॉ.एस.एम.पेरके)
जिल्हा शल्यचिकित्सक,
नांदेड

महाराष्ट्र शासन आरोग्य सेवा जिल्हा शल्यचिकित्सक, नांदेड (ग्रामीण रुग्णालय नियंत्रण कक्ष)	
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नियम व अटी :-

Voluntary Organization /NGO

- 1- A Society registered under the Indian Societies Registration Act,1860 (Act XXI of 1860 or any such act resolved by the state) or a charitable public trust registered under any law for the time being in force.
- 2- Track record of having experience in providing health services preferably eye care services over a minimum period 3 year. (Annexure I 4.2)
- 3- Properly Constituted managing body with its powers duties and responsibilities clearly defined and laid down in a written constitution. (Annexure I 6.1)
- 4- Services open to all without distinction of caste, creed, religion or language.
- 5- Having available well trained staff, infrastructure, equipment and the required managerial expertise to organize and carry out various activities under the scheme. (Annexure I 5.1,5.2,5.3)
- 6- Agreeing to abide by the guidelines and the norms of the program.
- 7- Registration on Darpan Portal of NitiAyog.


Dr.S.M.Perke
Civil Surgeon,Nanded

GOVERNMENT OF INDIA

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS AND VISUAL
IMPAIRMENT

Details of participating organization

ORGANIZATION PROFILE:

1. Name: _____
2. Address : _____

- State : _____ Pin Code: _____
- Tel : _____ Fax No.: _____
- No. _____

3. Legal Status

S. No.	Particulars	Registration No.
(i)	Public Charitable Trust	
(ii)	Society under Societies Registration Act	
(iii)	Non Profit company under Indian Companies Act	
(iv)	Registration under Foreign Contribution Act	
(v)	Income - Tax Registration	
	under Section 12A	
	under Section 80G	
	under Section 35CCA	
	any other Section	

4. Financial Status

4.1 Details of Bank Account:

Name of the Bank _____ Branch _____

Address _____

Type of account: Saving / Current Account No. _____

Is your account operated jointly? Yes / No

Name and Designation of the Signatories to the account:

Name	Designation

4.2 Financial profile of the applicant organization (last 3 years)

Year	Total Receipts	Audited Statement A/C for last 3 years.

4.3 Grants received from other Sources: Government and Non Government Organizations in the last 3 years of inception whichever is earlier:

S. No.	Government Organization	Details of Grant	Amount	Year
1				
2				
3				

S. No.	Non Government Organization	Details of Grant	Amount	Year
1				
2				
3				

5. Details of Existing Health Facility:

5.1 Infrastructure

		Area in Sq. ft.
No. of Eye Wards	_____	_____
No. of Eye Beds	_____	_____
No. of OTs	_____	_____
No. of Operation Tables	_____	_____

5.2 Manpower

Personnel	Nos	Qualification.
Eye Surgeons		
Other Doctors		
Nursing Staff		
Ophthalmic Assistants or equivalent		
Administrator		
Community Coordinator		
Clerks		
Driver		
Other (Specify)		

5.3 Equipment Status

Sr. No	Name of Equipment	Available	Number Required
1	TRIAL LENS SET		
2	TRIAL FRAME CHILD		
3	TRIALS FRAME ADULT		
4	NEAR VISION CHARTS		
5	DISTANT VISION CHARTS		
6	ROTATING TEST DRUM		
7	ISHIHARA COLOUR CHARTS		
8	TONOMETER		
9	DIRECT OPHTHALMOSCOPE		
10	BINOMAGS		
11	CORNEAL LOUPE		
12	SLIT LAMP		
13	APPLATION TONOMETER		
14	STREAK RETINOSCOPE		
15	INDIRECT OPHTHALMOSCOPE		
16	CATARACT SET FOR ECCE/IOL		
17	AMBU SETS WITH O2 CYLINDER		
18	OPERATION MICROSCOPE		
19	ULTRASOUND A- SCAN		
20	ULTRASOUND B- SCAN		
21	LASER : ARGON		
22	LASER ARGON- KRYPTON		
23	LASER YAG		
24	AUTO REFRACTOMETER		
25	ANTERIOR VITRECTOMY UNIT		
26	KEROTOMETER		
27	ANY OTHER EQUIPMENT, PLEASE SPECIFY		

Signed _____

Date _____

6.1 Details of Trustees of the NGO:-

Name	Designation	Address	Tel. No.

6.2 Past experience in (a) Health care delivery services

6.3 Past experience in (b) Eye care delivery services

7 Current Performance

Give details of current performance : (for last 3 years)

a) Base Hospital

Year	Free Subsidized					Paying				
	OPD		Indoor			OPD		Indoor		
	New	Review	ECCE /SICS	IOL*	Others	New	Review	ECCE /SICS	IOL*	Others

*IOL includes ECCE/IOL, SICS, Phaco

b. Details of Eye ball Collection for Eye Banks

Sr. No	Year	No. of eye balls collection	No of eye balls utilized	No. of eye balls discarded or disposed off	No. of Keratoplasty surgery done	No. of Keratoplasty Surgery done	No. of eye balls used for other purpose

C. Details of Eye Ball Collection for Eye Donation Centre (To be filled up in MIS)

No. of eye balls collected	No. of eye balls received from other institutes	No. of eye balls sent to Govt. Institution	No. of eye balls sent elsewhere for keratoplasty

Date:- _____

Signature of Ophthalmic Technician

Signature of authorized Signatory
with seal of the NGO

d) Outreach

Screening Camps Conducted				
Year	No. of Camps	No. of Outpatients	No of patients referred to base hospital	Actual No. reported to base Hospital

8. Enclosures to be added with the Application:

- i. Constitution of the organization Memorandum of Association.
- ii. Previous 3 years audited statement of accounts and balance sheets.
- iii. Annual Reports of previous 3 years including camps, if any.
- iv. Information sheet on details of the organization.
- v. Registration Certificate under Public Charities/Societies' Act.
- vi. Registration Certificate under Foreign Contribution Act, if applicable*.
- vii. List of the members of the Executive Committee.

*** Strike out whichever is not applicable.**