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Name & Designation of officer	**Dr. S.M. Perke, Civil Surgeon, District Hospital, Nanded**
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Document Title should be displayed as (in English)	**Notice for Appointment of NGO under -NPCB Programmer Civil Surgeon office Nanded Dist.Nanded**
Document size (Document should be in PDF format and size will not exceeded more than 20 MB)	**A4**

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Signature of Programme Authority

Date :-

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
npcb.nanded@gmail.com

जा.क्र.जिशचि/राअनिका/12365/२५. दिनांक : 31/10 /२०२५

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

Annexure I

GOVERNMENT OF INDIA

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS AND VISUAL IMPAIRMENT

Details of participating organization

ORGANIZATION PROFILE:

1. Name: _____
2. Address : _____
   _____
   _

   : _____ Pin Code:
   State _____

   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 Section12A	
	under Section 80G	
	under Section 35CCA	
	any other Section	

Financial Status

.1 Details of Bank Account:

ame of the Bank _____ Branch

_____

ddress

_____

ype of account: Saving / Current Account No.

_____

s 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	TRAILS 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