



द्वारा स्पीड पोस्ट/ई-मेल  
राजस्थान पैरामेडिकल कौंसिल, जयपुर

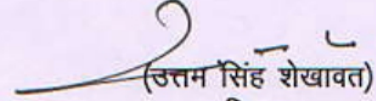
प्लॉट नं. 6, एवरेस्ट कॉलोनी, एपेक्स मॉल के पास, लाल कोठी, जयपुर।  
Website : rajasthanparamedicalcouncil.org, Contact : 0141-2973804, 2988946

क्रमांक:पैरामेडि.कौ/मान्यता/2020/ 53

दिनांक 18/09/2020

-:: संशोधित आदेश ::-

राजस्थान पैरामेडिकल कौंसिल, जयपुर द्वारा मान्यता शुल्क जमा करवाये जाने के क्रम के जारी आदेश क्रमांक 54 दिनांक 17.09.2020 में पैरामेडिकल पाठ्यक्रमों के संचालन हेतु मान्यता प्राप्त महाविद्यालयों/संस्थाओं द्वारा नियमानुसार प्रतिवर्ष RS. 25000/- मान्यता शुल्क देय है अंकित हो गया था, के स्थान पर पैरामेडिकल पाठ्यक्रमों के संचालन हेतु मान्यता प्राप्त महाविद्यालयों/संस्थाओं द्वारा नियमानुसार प्रतिवर्ष प्रति पाठ्यक्रम RS. 25000/- मान्यता शुल्क देय है, पढा जावे। शेष यथावत रहेगा।


  
(उत्तम सिंह शेखावत)  
रजिस्ट्रार

क्रमांक:पैरामेडि.कौ/मान्यता/2020/ 53

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प्रतिलिपि निम्न को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित है:-

1. विशिष्ट सहायक, माननीय मंत्री, चिकित्सा एवं स्वास्थ्य विभाग, जयपुर।
2. विशिष्ट सहायक, माननीय राज्य मंत्री, चिकित्सा एवं स्वास्थ्य विभाग, जयपुर।
3. प्रमुख शासन सचिव, चिकित्सा एवं स्वास्थ्य विभाग, जयपुर।
4. उप शासन सचिव, चिकित्सा एवं शिक्षा (ग्रुप-3) विभाग, जयपुर।
5. अध्यक्ष महोदय, राजस्थान पैरामेडिकल कौंसिल, जयपुर।
6. निजी सहायक, रजिस्ट्रार, राजस्थान पैरामेडिकल कौंसिल, जयपुर।
7. राजस्थान पैरामेडिकल कौंसिल से मान्यता प्राप्त समस्त पैरामेडिकल कॉलेजो/संस्थानों को भेजकर लेख है कि पत्र के साथ संलग्न प्रपत्र भी मान्यता शुल्क के साथ संलग्न कर भिजवावें।
8. प्रभारी सर्वर रूम को भेजकर लेख है कि उक्त आदेश आज ही वेबसाईट पर अलपोड करें।
9. रक्षित पत्रावली।

  
रजिस्ट्रार

To

The Registrar  
Rajasthan Para medical council  
Jaipur, Rajasthan

Subject:- Self declaration about infrastructure & facilities in the institution.  
Reference:- Your letter number.....Dated.....

In reference to the above cited letter, hereby submit and declare as under :-

1. Date of the application
2. Name of the Institution
3. Name of the Chairperson/Secretary
4. Name of the society/Trust/Company
5. Complete address where para medical course will run.
6. Name of the Principal/Dean/HOD with qualification
7. Name of the course undertaken and allowed annual admission.

| S. No. | Name of the Course | Number of Seats |
|--------|--------------------|-----------------|
|        |                    |                 |
|        |                    |                 |
|        |                    |                 |
|        |                    |                 |
|        |                    |                 |
|        |                    |                 |
|        |                    |                 |

8. Other courses running in the same premises.
9. Physical Facilities are available as per norms (please sign in Yes or No column only) :-

| S.No. | Description               | Area  | Yes | No |
|-------|---------------------------|---|-----|----|
| 1     | Principal Office (1)      |   |     |    |
| 2     | Office Facilities         |   |     |    |
| 3     | Number of Class Rooms (2) |   |     |    |
| 4     | Number of Labs (1)        |   |     |    |
| 5     | Library (1)               |   |     |    |
| 6     | Common facilities         |   |     |    |
| 7     | Transportation Facilities | Sufficient number of vehicles required as per sanctioned seats. |     |    |
| 8     | Boys and Girls Hostel     | Desirable   |     |    |
| 9     | Sports Facilities         | Desirable   |     |    |

[Type text]

This form is to be signed on each page.

[Type text]

10. Library Facilities are available as per norms (mention Yes or No).

11. Clinical Facilities are available as per norms (please sign in Yes or No column only) :-

| S. No. | Particulars                                       |   |                                      |
|--------|---|---|--------------------------------------|
| 1.     | Name of Own Hospital/Lab.                         |   |                                      |
| 2.     | Proof of the Hospital/Lab being Own Hospital/Lab. |   |                                      |
| 3.     | Beds distribution.                                |   |                                      |
| 4.     | Pollution Control Board Certificate.              |   |                                      |
| 5.     | Clinical Establishment Registration.              |   |                                      |
| 6.     | Distance of institute from Hospital/Lab. in K.M.  |   |                                      |
| 7.     | Course-wise clinical facilities                   |   |                                      |
|        | Name of Course                                    | Details of clinical facilities available. | facilities are as per Norms – Yes/No |
|        |   |   |                                      |
|        |   |   |                                      |
|        |   |   |                                      |
|        |   |   |                                      |
|        |   |   |                                      |
|        |   |   |                                      |
|        |   |   |                                      |
|        |   |   |                                      |

12. Teaching Facilities available:-

| S. No. | Name of the faculty | Qualification | Teaching Experience | Date of Joining | Part time/Full time |
|--------|---------------------|---------------|---------------------|-----------------|---------------------|
|        |                     |               |                     |                 |                     |

Teaching facilities is as per Norms

|     |    |
|-----|----|
| Yes | No |
|-----|----|

13. Required Equipments as per norms are available – Yes/No (List to be enclosed.)

14. Video-graphy of required infrastructure facility to be enclosed (No. of CD enclosed - .....)

15. Any other information

Date :

Place :

Signature and Name  
of Principal

[Type text]

This form is to be signed on each page.

[Type text]

**DECLARATION**

I..... S/o .....  
having present residential address .....  
..... am  
the principal of college (with address) .....  
.....  
..... hereby declare that the statement and declaration furnished by the  
institution, whose principal I am, are true to the best of my knowledge and belief  
and that I am free from the disqualification mentioned in the Rajasthan Para-  
medical Council Act, 2008, rules and regulations. I promise in the event of being  
granted extension of recognition and in consideration thereof to be bound by and to  
confirm in all respects to the rules, regulation etc. framed by Council from time to  
time in force.

**Place :**

**Date :**

Seal & Signature of Principal

**Note:-**

1. Please attach Xerox-copy of photo id.
2. It is compulsory to give the declaration on Non-Judicial Stamp paper of 100/- Rupees.

