EMPLOYER REGISTRATION FORM

Organization Details

Hospital / Organization Name: _____

Type: □ Hospital □ Nursing Home □ Clinic □ Diagnostic Centre □ Insurance Company □ Healthcare BPO □ Medical College □ Other

Registered Address: _____

City: _____

State: _____

Website: _____

GST Number: _____

PAN Number: _____

Number of Beds: _____

NABH Status: □ Accredited □ Applied □ Not Accredited

Contact Person Details

Name: _____

Designation: _____

Mobile: _____

Email: _____

Declaration

We certify that all information furnished is true and correct.

We agree to comply with applicable labour laws and recruitment regulations.

Authorized Signatory

Name: _____

Signature: _____

Date: _____