



National Registry of Assisted Reproductive Technology (ART) Clinics and Banks in India

Indian Council of Medical Research

Pre-Enrollment Form

For the registration under “**National Registry of Assisted Reproductive Technology (ART) Clinics and Banks in India**”, Please fill the complete details in the table given below:

1. Name of the ART Clinic or ART Bank :	
2. Name of the Director of the ART Clinic/Hospital/Institution or ART Bank :	
3. Name of the In-charge of ART Clinic or ART Bank :	
4. Full Postal Address of ART Clinic or ART Bank (including City, State and Pin code) :	
5. Contact Details (Tel No. with STD code, Mob No. and Fax No.):	Phone : Mobile : Fax :
6. Email address of In-charge :	
7. Website address (if any) :	
8. Do you wish to register your clinic as an ART clinic or ART bank? (If you have both, kindly indicate whether you want to register your unit as an ART Clinic or ART Bank ?)*	
9. Do you have more than one ART Clinic or Bank at same or different places performing various ART procedures as per the announcement? (Yes/No)	
10. If Yes, Please send the full details in above mentioned format of the other ART Clinics or ART Banks.	

Signature:

Name:

(Director/ In-charge of the Clinic or Bank with seal)

* According to the draft ART (Regulation) Bill, ART clinic and ART bank have to be two separate independent institution and should be registered independently with different address, identity and organizational structure .

ART Clinic: “Assisted Reproductive Technology Clinic”, means any premises used for procedures related to Assisted Reproductive Technology.

The following are the procedures are being followed by the ART Clinics:

- Artificial Insemination with Husband’s Semen (AIH)
- Artificial Insemination with Donor Semen (AID)
- Intra-uterine Insemination using Husband Semen (IUI-H)
- Intra-uterine Insemination using Donor Semen (IUI-D)
- *In vitro* Fertilization-Embryo Transfer (IVF-ET)
- Commercial Surrogacy
- Altruistic Surrogacy
- Gamete Intrafallopian Tube Transfer (GIFT)
- Intra-cytoplasmic Sperm Injection (ICSI)
- Physiological Intra-cytoplasmic Sperm Injection (PICSI)
- Intra-cytoplasmic Morphologically Selected Sperm Injection (IMSI)
- Round Spermatid Nucleus Injection (ROSNI)
- Elongated Spermatid Injection (ELSI)
- Percutaneous Epididymal Sperm Aspiration (PESA)
- Microsurgical Epididymal Sperm Aspiration (MESA)
- Testicular Sperm Aspiration (TESA)
- Testicular Sperm Extraction (TESE)
- Pre-implantation Genetic Diagnosis (PGD)
- Pre-implantation Genetic Screening (PGS)
- Blastocyst Separation Technique
- Endometrial Receptivity Array
- Time Lapse Imaging
- Processing or storage of gametes (sperm and oocyte) and or embryos of infertile patient

ART Banks: “ART Banks”, means an organisation that is set up to supply sperm/semen, oocytes/oocyte donors and surrogate mothers to Assisted Reproductive Technology Clinics or their patients.

The following are the responsibilities of the ART Banks:

- (i) Advertising for sperm/semens and oocytes donors.
- (ii) Clinical and laboratory examination of the donors.
- (iii) Processing and cryopreservation of the sperm.
- (iv) Ovarian stimulation, ovum pickup and cryopreservation of the oocytes.
- (v) Advertising for surrogate mothers and clinical and laboratory examination of the surrogate mother.
- (vi) Undertaking and maintaining all agreements of donors, surrogate mothers and of infertile couples coming for donors and for hiring surrogate mothers.

Note: If ART Bank then do not proceed further, a separate proforma will be sent for ART Bank.



Indian Council of Medical Research

National Registry of Assisted Reproductive Technology (ART) Clinics and Banks in India

Proforma for Infrastructure Facilities, Trained Manpower Available and Procedures being undertaken at ART Clinic

SECTION- I (GENERAL INFORMATION)

Please follow the instructions given in the Instruction Manual while filling the proforma and use capital letters only.

Name of the ART Clinic: _____

Name of the In-charge of the ART Clinic: _____

Name of the Director of the ART Clinic/Hospital/Institution: _____

Address of ART clinic: _____

_____ City: _____

District: _____ State: _____ Pin Code:

Telephone No. (with STD Code) (ART Clinic only): _____

Mobile No. of Director (ART Clinic/Hospital/Institution): _____

Mobile No. of In-charge (ART Clinic): _____

Fax No. (ART Clinic only): _____

E-mail (In-charge of the ART Clinic): _____

Website: _____

(Please do not fill this type of Boxes "[]", to be filled by ICMR)

1. Card No.



2. State: [] []
 (**Note:** Please write the name of your State in the space provided above)
3. Enrollment No. [] [] [] [] [] []
4. Date of filling the form [] [] [] [] [] []
5. Whether your ART Clinic is []
 1. National 2. International
 (**Note:** If your ART clinic is National, then skip to Question No. 8)
6. If the ART Clinic is international, then please mention whether the head clinic or []
 main clinic is located in
 1. India 2. Outside India
7. If head clinic is outside India, then please specify whether the Director/Owner is []
 1. Non Resident Indian 2. Foreigner
8. Status of your ART Clinic []
 1. Government 2. Semi-Government 3. Private
 4. Charitable Trust 5. NGO 6. Public Sector Undertaking
 7. Any other, please specify.....
9. Whether your ART Clinic is Allopathic []
 1. Yes 2. No
 (**Note:** If your ART clinic is Allopathic, then skip to Question No. 11)
10. If No, then please specify [] []
11. Date of establishment of your ART Clinic [] [] [] [] [] []
12. Whether your ART Clinic is registered under the following Acts/Authorities (Please provide details)

(1) S. No.	(2) Name of the authority	(3) 1. Yes 2. No	(4) If Yes, then please specify the Registration Number	(5) State of Registration authority (write in space provided below)	(6) Date of Reg. (DD-MM-YY)	(7) Validity of Registration (in years)	(8) If No, then please specify reason in space provided
1.	Accreditation with International Organization for Standardization (ISO)	<input type="checkbox"/> [] []	[] [] [] [] [] []	<input type="checkbox"/> [] []
2.	Medical Termination of Pregnancy (MTP) Act	<input type="checkbox"/> [] []	[] [] [] [] [] []	<input type="checkbox"/> [] []
3.	Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act	<input type="checkbox"/> [] []	[] [] [] [] [] []	<input type="checkbox"/> [] []

4.	Bio-Medical Waste (Management and Handling) Rules	<input type="checkbox"/> []	[][] [][][] [][][]	<input type="checkbox"/> []
5.	Clinical Establishment Act	<input type="checkbox"/> []	[][] [][][] [][][]	<input type="checkbox"/> []
6.	NOC from Fire Safety Department	<input type="checkbox"/> []	[][] [][][] [][][]	<input type="checkbox"/> []

13. Whether your ART clinic is registered with any other authority in addition to above
 1. Yes 2. No

(Note: If No, then skip to question no. 15)




14. If yes, then please give the details

(1) S. No.	(2) Name of the authority	(3) Whether authority is 1. Central Govt. 2. State Govt. 3. Both 4. Any other	(4) Registration Number	(5) State of Registration authority (write in space provided below)	(6) Date of Reg. (DD-MM-YY)
1. []	<input type="checkbox"/> []	[][] [][][] [][][]
2. []	<input type="checkbox"/> []	[][] [][][] [][][]
3. []	<input type="checkbox"/> []	[][] [][][] [][][]
4. []	<input type="checkbox"/> []	[][] [][][] [][][]
5. []	<input type="checkbox"/> []	[][] [][][] [][][]

15. Whether your ART clinic is within a hospital/Institution
 1. Yes 2. No
 (Note: If No, then skip to question no. 17)
16. If Yes, then please provide the Name and Address of the hospital/Institution

17. Whether your hospital/Institution is having more than one ART clinics within the country
 1. Yes 2. No
 (Note: If No, then skip to question no. 22)
18. If Yes, then please indicate whether your ART clinic is
 1. Head Clinic 2. Sub-clinic/Branch
 (Note: If Sub-clinic/Branch then skip to question no. 21.)
19. If head clinic, please specify total number of sub-clinics/branches under head clinic
20. Please give the name, address and contact details of the sub-clinics/branches which are situated in different regions of the country under the head clinic

(1) S. No.	(2) Name of sub-clinic/branch	(3) State (write in space provided below)	(4) Address & contact details (In-charge only) of sub-clinics/branches	(5) Enrollment No. (If already obtained from National Registry of ART Clinics and Banks in India of ICMR)
1. <div style="border: 1px dashed red; width: 40px; height: 20px; margin: 0 auto;"></div> Mob: Email:	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>
2. <div style="border: 1px dashed red; width: 40px; height: 20px; margin: 0 auto;"></div> Mob: Email:	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>

3.  Mob: Email:	<table border="1" data-bbox="1258 178 1477 220"> <tr> <td></td><td></td><td></td><td></td><td></td> </tr> </table>					
4.  Mob: Email:	<table border="1" data-bbox="1258 472 1477 514"> <tr> <td></td><td></td><td></td><td></td><td></td> </tr> </table>					
5.  Mob: Email:	<table border="1" data-bbox="1258 756 1477 798"> <tr> <td></td><td></td><td></td><td></td><td></td> </tr> </table>					

(Note: If more than five sub-clinics/branches, then please add separate sheets accordingly)

21. If sub-clinic/branch, please provide the following details of the Head clinic

a) Enrollment no. issued by **National Registry of ART clinics and Banks in India of ICMR** to Head clinic

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b) Address of Head clinic.....

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.....

c) Mobile no. of In-charge

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SECTION - II (MANPOWER)

Details of the Staff Available at your ART Clinic:

22. Whether your ART Clinic/hospital has Director
 1. Yes 2. No

23. If yes, give the details of qualification of Director

Qualification

Please indicate the highest qualification/degree

(1) Sl. No.	(2) Name of the degree 1. Ph.D./DM/M.Ch. 2. PG/MD/MS/DNB 3. PG Diploma 4. Diploma 5. Graduate/MBBS 6. Any other	(3) Area/Discipline 1. Medicine 2. Life Sciences 3. Any other	(4) Whether 1. Regular 2. Part-time	(5) Experience in Infertility /ART (in yrs)
1. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/>

(Note: Please enter the code in the given box and write degree in the space given above.)

24. Whether your ART Clinic has In-charge
 1. Yes 2. No

(Note: In-charge of the ART clinic should be a trained gynecologist having appropriate degree as per ICMR ART guidelines and should conduct & supervise all the ART procedures at the ART clinic.)

25. If yes, give the details of qualification of the In-charge

Qualification

Please indicate the highest qualification/degree

(1) Sl. No.	(2) Name of the degree 1. DM/M.Ch. 2. MD/MS/DNB 3. PG Diploma 4. Any other	(3) Area/Discipline 1. Obst. & Gynecology 2. Any other	(4) Whether 1. Regular 2. Part-time	(5) Experience in ART (in yrs)
1. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/>

(Note: Please enter the code in the given box and write degree in the space given above.)

26. Whether your ART Clinic has more than one Gynecologist
 1. Yes 2. No

27. If yes, please indicate the total number of Gynecologists

28. Give the details of qualification of Gynecologist

Qualification

Please indicate the highest qualification/degree

(1) Sl. No.	(2) Name of the degree 1. DM/M.Ch. 2. MD/MS/DNB 3. PG Diploma 4. Any other	(3) Area/Discipline 1. Obst. & Gynecology 2. Any other	(4) Whether 1. Regular 2. Part-time	(5) Experience in ART (in yrs)
1. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
2. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
3. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>

Note: (i) Please enter the code in the given box and write degree in the space given above.

(ii) If more than three, then please add separate sheets accordingly.

29. Whether your ART Clinic has Andrologist
1. Yes 2. No

30. If yes, then please indicate the total number of Andrologists

31. Give the details of qualification of Andrologist

Qualification

If more than one Andrologist then enter the information below from Serial no. 2 onwards otherwise leave blank.

Please indicate the highest qualification/degree

(1) Sl. No.	(2) Name of the degree 1. Ph.D./DM/M.Ch. 2. MD/MS/DNB 3. PG Diploma 4. Any other	(3) Area/Discipline 1. Urology 2. General Surgery 3. Any other	(4) Whether 1. Regular 2. Part-time	(5) Experience in Andrology (in yrs)
1. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
2. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
3. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>

Note: (i) Please enter the code in the given box and write degree in the space given above.

(ii) If more than three, then please add separate sheets accordingly.

32. Whether your ART Clinic has Clinical Embryologist
1. Yes 2. No

33. If yes, then please indicate the total number of Clinical Embryologists

34. Give the details of qualification of Clinical Embryologist

Qualification

If more than one Clinical Embryologist then enter the information below from Serial no. 2 onwards otherwise leave blank.

Please indicate the highest qualification/degree

(1) Sl. No.	(2) Name of the degree 1. Ph.D./DM/M.Ch. 2. PG/MD/MS/DNB/M.V.Sc. 3. PG Diploma 4. Diploma 5. MBBS/B.V.Sc./B.Sc. 6. Any other	(3) Area/Discipline 1. Medicine 2. Life Sciences 3. Veterinary Sciences 4. Any other	(4) Whether 1. Regular 2. Part-time	(5) Experience in Embryology (in yrs)
1. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
2. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
3. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>

Note: (i) Please enter the code in the given box and write degree in the space given above.
(ii) If more than three, then please add separate sheets accordingly.

35. Whether your ART Clinic has Counselor
1. Yes 2. No

36. If yes, then please indicate the total number of Counselors

37. Give the details of qualification of Counselor

Qualification

If more than one Counselor then enter the information below from Serial no. 2 onwards otherwise leave blank.

Please indicate the highest qualification/degree

(1) Sl. No.	(2) Name of the degree 1. Ph.D./DM/M.Ch. 2. PG/MD/MS/DNB 3. PG Diploma 4. Diploma 5. Graduate/MBBS 6. Any other	(3) Area/Discipline 1. Social Sciences 2. Psychology 3. Life Sciences 4. Medicine 5. Any other	(4) Whether 1. Regular 2. Part-time	(5) Experience in Counseling in ART (in yrs)
1. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
2. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
3. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>

(Note: Please enter the code in the given box and write degree in the space given above.)

(Note: A member of the staff of an ART clinic who is not engaged in any other full-time activity in the ART clinic can act as a counselor. Counselor has to be independent.)

38. Number of staff members other than the specified above employed in your ART Clinic

39. Please provide the details of the other staff members in the table given below:

(1) Sl. No	(2) Name of the Post	(3) Qualification 1. Doctorate 2. Post Graduate 3. Graduate 4. Diploma 5. Under Graduate 6. Any other	(4) Area/Discipline 1. Medicine 2. Nursing 3. Life Sciences 4. Social Sciences 5. Psychology 6. Any other	(5) Whether 1. Regular 2. Part-time	(6) No. of Post
1.	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>

(Note: If more than 10, then please add separate sheets accordingly.)

SECTION - III (INFRASTRUCTURE)

Infrastructure Facilities Available at ART Clinic

40. Does your ART clinic has Non Sterile Area
1. Yes 2. No
41. If yes, whether the Non Sterile Area is provided with
1. Yes 2. No
(**Note:** Enter the code i.e. 1 or 2 in the boxes accordingly)
- a. Reception area
 - b. Waiting room for patients
 - c. Examination room with privacy
 - d. A general purpose clinical laboratory
 - e. Store room
 - f. Record room
 - g. Autoclave room
 - h. Semen collection room
42. Whether your ART clinic has Provision for vermin proofing
1. Yes 2. No
43. Does your ART clinic has Sterile Area
1. Yes 2. No
44. If yes, whether Sterile Area is provided with
1. Yes 2. No
(**Note:** Enter the code i.e. 1 or 2 in the boxes accordingly, In case of not applicable then enter 9 in the box)
- a. Area for changing into sterile garments
 - b. Semen processing laboratory (as per GLP)
 - c. Operation Theatre well equipped for carrying out surgical endoscopy, transvaginal ovum pick-up, Embryo transfer and should be equipped for Emergency resuscitative procedures
 - d. Embryology Laboratory Complex
 - e. Operating table for carrying out the procedures
 - f. Whether the sterile area is air conditioned with fresh air filtered through an appropriate filter systems along with ambient temperature of 22°C – 25°C (Air Handling Unit)
 - g. Pre and Post operation areas

- t. Temperature
- u. CO₂ analyzer
- v. Volatile Organic Compounds (VOCs) Filtration system
- w. IVF Software
- x. Ovum Pick-Up (OPU) Pump
- y. CCD Monitoring System
- z. IVF Witness System
- aa. Auto-analyzer for Sperm Function Test
- bb. Computer Assisted Semen Analysis (CASA)
- cc. CO₂ and Triple gas Manifold
- dd. Makler Chamber
- ee. Cryofreezer
- ff. Whether you have separate incubators for
 - I. Oocytes
 - II. Sperms
- gg. To avoid mixing of gametes or embryos whether proper labeling of patient's name is being done on
 - I. All tubes
 - II. Dishes
 - III. Transfer pipettes
- hh. Whether all used pipettes are immediately discarded
- 46. Whether your ART Clinic has got hormone assay facility
 - 1. Yes
 - 2. No

(**Note:** If No, then skip to Question No. 48)
- 47. If yes, whether performing following hormone and other assay at your clinic
 - 1. Yes
 - 2.No

(**Note:** Enter the code i.e. 1 or 2 in the boxes accordingly)

 - a. FSH
 - b. LH
 - c. Prolactin
 - d. hCG
 - e. TSH
 - f. Estradiol
 - g. Progesterone

- h. Testosterone
- i. DHEA
- j. HIV
- k. Hepatitis B
- l. HCV
- m. VDRL
- n. AMH
- 48. Whether outsourcing from specialty laboratory
 1. Yes 2. No
- 49. If yes, whether outsourcing from
 1. Single Laboratory 2. Multiple Laboratories
 (**Note:** If Single Laboratory, then skip to Question No. 51)
- 50. If multiple laboratories, please specify the number of laboratories
- 51. Name and distance (in kms) of the outsourcing Laboratories from your ART Clinic
 - a. (i) Name.....
 (ii) Distance
 - b. (i) Name.....
 (ii) Distance
 - c. (i) Name.....
 (ii) Distance
- 52. Whether the result of Estradiol test is used for determining the dose of drug required for induction of ovulation
 1. Yes 2. No
- 53. Do you have Microbiology Lab
 1. Yes 2. No
 (**Note:** If Yes, then skip to Question No. 56)
- 54. If no, whether outsourcing from specialty laboratory
 1. Yes 2. No
- 55. If yes, distance (in kms) between your ART clinic and specialty laboratory
- 56. If you have microbiology laboratory then please indicate whether it can carryout rapid test for any infection
 1. Yes 2. No
- 57. If no, specify the reason
- 58. Do you have Clinical Chemistry Laboratory
 1. Yes 2. No
 (**Note:** If Yes, then skip to Question No. 61)

59. If no, whether outsourcing from specialty laboratory
 1. Yes 2. No
60. If yes, distance (in kms) between your ART clinic and specialty laboratory
61. Do you have facility for carrying out Histopathological Studies
 1. Yes 2. No
 (**Note:** If Yes, then skip to Question No. 64)
62. If no, whether outsourcing from specialty laboratory
 1. Yes 2. No
63. If yes, distance (in kms) between your ART clinic and specialty laboratory
64. Whether the following are periodically checked for microbial contamination using standard techniques
 1. Yes 2. No
 (**Note:** Enter the code i.e. 1 or 2 in the boxes accordingly)
- a. Laminar flow hoods
- b. Laboratory tables
- c. Incubators
- d. Lab, OT walls and floor
65. Whether records of such checks are properly maintained at the clinic
 1. Yes 2. No
66. If no, specify the reason
67. Are you performing the following for maintenance of the laboratories:
 1. Yes 2. No
 (**Note:** Enter the code i.e. 1 or 2 in the boxes accordingly)
- a. Maintaining in writing, standard operating manuals
- b. Daily Log Book for recording the following in the incubator
- I. Temperature
- II. Humidity
- III. CO₂ content
- c. Record Book for calibration of all equipments
- d. Are you performing the following in your laboratories:
- I. Volatile organic compounds (VOCs)
- II. Particle count
68. Whether quality consumables like disposable plastic ware are procured from reliable sources in the laboratory
 1. Yes 2. No
69. Whether the plastic ware used are non-toxic to the embryos/ gametes
 1. Yes 2. No

70. Whether the Culture Media used is commercial
 1. Yes 2. No
 (Note: If No, then skip to Question No. 72)
71. If Yes, please indicate whether the composition of media is known to the clinical embryologist
 1. Yes 2. No
72. If Culture Media is prepared at centre then please indicate whether Culture Media tested for the following regularly at the Clinic
 1. Yes 2. No
 (Note: Enter the code i.e. 1 or 2 in the boxes accordingly)
- a. Sterility
 - b. Endotoxins
 - c. Osmolality
 - d. pH
 - e. Nucleic Acid Amplification Testing
 - f. Mouse Embryo Assay Testing
 - g. Limulus Amebocyte Lysate Testing
 - h. Sterility Assurance Level Testing
 - i. Hepatitis-B Surface Antigen
 - j. Hepatitis-C RNA
73. Whether an appropriate provision for back-up power supply available at our ART clinic
 1. Yes 2. No
 (Note: If No, then skip to Question No. 75)
74. If yes then which of the following are being used
 1. Yes 2. No
 (Note: Enter the code i.e. 1 or 2 in the boxes accordingly)
- a. UPS System
 - b. Captive power generative system
 - c. Both
 - d. Other, please specify
75. If No, please specify the reasons.....

77. Whether you have any facility for cryopreservation of infertile patients sperm/oocyte and or embryo
1. Yes 2. No
78. If yes, then please provide the details
1. Yes 2. No
- a. Freezing of sperm
- I. Sperm slow freezing
- II. Sperm vitrification
- b. Freezing of oocytes
- I. Oocyte slow freezing
- II. Oocyte vitrification
- c. Freezing of zygotes
- I. Zygotes slow freezing
- II. Zygotes vitrification
- d. Freezing of embryos
- I. Day 2
- II. Day 3
- III. Day 4
- IV. Day 5/6
- e. Cryopreservation of ovarian tissue
- f. Freezing of Testicular tissue
79. Kindly indicate the provision/facility available at your ART Clinic
1. Yes 2. No
- (Note: Enter the code i.e. 1 or 2 in the boxes accordingly)

(I). Work-up

- a. Diligent history taking
- b. Counseling

(II). Male Factors

- a. Treatment of oligozoospermia
- b. (i) Detecting infection of the reproductive tract using appropriate diagnostic test
- (ii) If yes, please specify the procedure
1. Routine Test 2. Culture Test (antibiotic sensitivity test) 3. Both
- c. Immunological test for infertility
- d. Provision for semen collection in men with a vibrator or an Electroejaculator in erectile dysfunction and ejaculatory problems

- e. Procedures for IUI
 - i). Wash and swim-up
 - ii). Density gradient
 - iii). Sperm recovered from post-coital specimen of urine in retrograde ejaculation
- f. Karyotyping

(III). Female Factors

- a. Treatment of minor anatomical defects like imperforate hymen
- b. Treatment of endometriosis after confirming its presence by diagnostic laparoscopy
- c. Induction of ovulation in anovulatory women with drugs such as Clomiphene Citrate etc.
 - i) With adjuncts like bromocriptine, eltroxin, dexamethasone or spironolactone
 - ii) Without adjuncts like bromocriptine, eltroxin, dexamethasone or spironolactone
- d. Please specify the drug being used routinely for ovulation induction
 - I. In IUI
 - i). Clomiphene Citrate (CC)
 - ii). Letrozole
 - iii). Gonadotrophins
 - iv). Gonadotrophins+Letrozole
 - v). Any other, please specify.....
 - II. In IVF
 - i). Clomiphene Citrate (CC)
 - ii). Letrozole
 - iii). Gonadotrophins+Letrozole
 - iv). Agonist protocol
 - v). Antagonist protocol
 - vi). Any other, please specify.....
- e. Correcting endocrine disorders such as
 - I. Thyroid disorders
 - II. Hyperprolactinemia
- f. (i) Detecting infection of the reproductive tract using appropriate diagnostic

test

(ii) If yes, please specify the procedure

1. Routine Test 2. Culture Test (antibiotic sensitivity test) 3. Both

- g. Conservative surgery either through a
 - i). Laparoscopy
 - ii). Hysteroscopy
 - iii). Laparotomy
- h. Combined medical-surgical therapy by a co-ordinated team, for example in endometriosis
- i. Assessment of follicular growth and ovulation by serial ultrasonography
- j. Immunological tests for infertility
- k. Tests for antibodies (IgG, IgA) against sperm antigen in cervical mucous
- l. Assessment of follicular growth and ovulation by serial transvaginal sonography (TVS)
- m. Provision for extended treatment of infertility except for oocyte pick up
- n. Karyotyping
- o. Saline Sono Salpingography
- p. Hysterosalpingogram (HSG)

(IV) Andrology

A. Basic

- a. Basic investigations such as physical examination and semen analysis (as per WHO method)
- b. If not following WHO method for semen analysis then please specify the other method being used
- c. Assessment of cell contaminants, debris and infection
- d. Assessment of seminal plasma for
 - i). Viscosity
 - ii). Liquefaction
 - iii). Blood contamination
 - iv). Accessory gland markers

B. Advanced (sperm function test)

- a. Sperm Function Test like hypo-osmotic swelling test (HOST)

- b. Assessment of the improvement of sperm motility potential with pentoxifylline co-culture
- c. Tests for sperm function and integrity such as acrosome reaction and sperm-oocyte interaction *in-vitro*

80. Category of the ART Clinic
 1. Primary 2. Secondary 3. Tertiary 4. Any other

81. Registration Number to be provided by ICMR.
- a). Nationality:
 - b). State:
 - c). Board (State/Central):
 - d). Facility (ART Clinic/ART Bank):
 - e). Multiple/Single:
 - f). Category:
 - g). Enrollment Number:

DECLARATION

I hereby declare that the entries in this form and the additional particulars, if any, furnished herewith are true to the best of my knowledge and belief.

Date: _____

(Signature of In-charge of the ART Clinic)

Name:

Designation with Seal:

(Signature of Director of the ART Clinic/Hospital/Institute)

Name:

Designation with Seal:

Note: Kindly submit the following documents along with duly filled proforma:

1. Copies of duly attested (Self / In-charge of ART Clinic) highest degree only of Director, In-charge, Gynaecologists, Andrologists, Clinical Embryologists and Counselors.
2. Experience certificate on the letter head of the Director or In-charge of the ART clinic where the following staff members are presently employed
 - a) Director b) In-charge c) Gynaecologists
 - d) Andrologists e) Clinical embryologists f) Counselors
3. Copy of duly attested certificates of the following:
 - a) International Organization for Standardization (ISO)
 - b) Medical Termination of Pregnancy (MTP) Act
 - c) Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act
 - d) Bio-Medical Waste (Management and Handling) Rules
 - e) Clinical Establishment Act
 - f) NOC from Fire Safety Department etc.
4. Enclosed documents should be properly labeled and number.

Indian Council of Medical Research

National Registry of Assisted Reproductive Technology (ART) Clinics and Banks in India

Instruction Manual for Filling up the Proforma for Infrastructure Facilities, Trained Manpower available and Procedures being undertaken at ART Clinic

SECTION- I (GENERAL INFORMATION)

Please write the name of the ART clinic, name of the Director, In-charge and address, telephone number, fax number, e-mail ID and website address of the ART clinic in **capital letters** in the space provided. Kindly provide mobile numbers of the Director and In-charge of the ART clinic in the space provided.

Please fill the code according to the instruction given in the manual starting from Question no.1 and enter the proper code in dark boxes “” and other necessary information in the space provided only in capital letters.

Note: Please do not fill dotted boxes “”.

1. Card No. will be given by ICMR (**please do not fill the dotted boxes**).
2. Write the Name of the State in the given space (**please do not fill the dotted boxes**).
3. Enrollment No. will be given by ICMR (**please do not fill the dotted boxes**).
4. Please fill the date of filling the form in the given boxes in **DD/MM/YY** format.
5. Fill in the given box ‘1’ for National, ‘2’ for International. In case ART clinic is National then skip to Question no. 8 otherwise continue.

“**National**” means your clinic and/or branches of your ART Clinics are situated in any city or state of India only.

“**International**” means your clinic and/or branches of your ART Clinics are situated in India and other countries also.

6. If the ART Clinic is international, then please fill in the given box ‘1’ for India and ‘2’ for Outside India.
7. If the Director/Owner is Non Resident Indian (NRI), then please fill ‘1’ and in case the Director/Owner has a citizenship of country other than India then please fill ‘2’ for Foreigner in the given box.
8. Fill in the given box ‘1’ for Government, ‘2’ for Semi-Government, ‘3’ for Private, ‘4’ for Charitable Trust, ‘5’ for Non-Government Organization (NGO), ‘6’ for Public Sector

Undertaking and '7' for Any other and in case of **Any other**, please write the status in the space provided.

9. Fill in the given box '1' for Yes and '2' for No. In case your ART clinic is Allopathic, then skip to Question No. 11 otherwise continue.
10. If your ART clinic is not Allopathic then specify in space provided and do not fill the dotted boxes.
11. Please fill the date of establishment of your ART Clinic in given boxes in **DD/MM/YY** format.
12. In case your ART Clinic is registered under the following Acts/Authorities specify in column no. 2, then please write the following details such as
 - **In column 2 of the table:** If your ART clinic is registered with the mentioned Acts/authorities then reply in column 3, 4, 5, 6, 7 and 8 respectively.
 - **In column 3 of the table:** Fill in the given box '1' for Yes, '2' for No.
 - **In column 4 of the table:** In case your ART clinic is enrolled with respective Acts/authorities then write the Registration number in the space provided.
 - **In column 5 of the table:** Write the name of the state of Registration authority from where your ART Clinic obtained this registration number in the space provided and do not fill the dotted boxes.
 - **In column 6 of the table:** Fill the date of registration when your ART Clinic was registered under that Acts/authority in the given boxes in **DD/MM/YY** format.
 - **In column 7 of the table:** Fill the Validity of Registration (in years) in given boxes.
 - **In column 8 of the table:** In case your ART clinic is not registered with respective Act/authority, then please specify reason in space provided and do not fill the dotted boxes.
13. In case ART clinic is registered with any other authority in addition to specify Acts/Authorities in Question no. 12, then fill '1' for Yes and '2' for No. If No, then skip to Question no. 15 otherwise continue.
14. In case ART clinic is registered with any other authority in addition to specify Acts/Authorities in Question no. 12, then
 - **In column 2 of the table:** Write the name of the authority in the space provided and do not fill the dotted boxes.
 - **In column 3 of the table:** Fill in the given box '1' for Central Govt., '2' for State Govt., '3' for Both and '4' for Any Other.
 - **In column 4 of the table:** Write the Registration number in the space provided.
 - **In column 5 of the table:** Write the name of the State in the space provided from where your ART Clinic obtained this registration number and do not fill the dotted boxes.

- **In column 6 of the table:** Fill the date of registration when your ART Clinic was registered under that authority in the given boxes in **DD/MM/YY** format.
15. Fill in the given box '1' for Yes and '2' for No. If your ART clinic is not within a hospital/Institution, then skip to Question no. 17 otherwise continue.
 16. In case your ART clinic is within a hospital/Institution, then specify the address of hospital/Institution in space provided.
 17. Fill in the given box '1' for Yes and '2' for No. In case your hospital/Institution is not having more than one ART clinics within the country, then skip to Question no. 22, otherwise continue.
 18. Fill in the given box '1' for Head Clinic/ Facility and '2' for Sub-clinic/ Branch. In case ART clinic is Sub-clinic/Branch, then skip to question no. 21, otherwise continue.

"Head Clinic" means central/main clinic coordinating the activities and also owns the responsibility of all its branches or sub-clinics.

"Sub-Clinic" is a clinic though running independently but is under coordination of the head clinic.
 19. Specify total number of sub-clinics/branches under head clinic in given boxes.
 20. Please give the name, address and contact details of the sub-clinics/branches which are situated in different regions of the country under the head clinic, such as
 - **In column 2 of the table:** Write the name of sub clinic/branch in the space provided.
 - **In column 3 of the table:** Write the name of the state in space provided where sub-clinics/branches is situated and do not fill the dotted boxes.
 - **In column 4 of the table:** Write the address of sub-clinic/branch, mobile no. and email address of only In-charge of sub-clinic/branch in the space provided.
 - **In column 5 of the table:** Fill the enrollment no. in the given boxes if already obtained from the **National Registry of ART Clinics and Banks in India** of **ICMR**.

Note: If you have more than five sub-clinics/branches, please attach the separate sheets and fill accordingly.

21. If ART clinic is sub-clinic/branch then provide the following details of the Head clinic
 - a) Fill the enrollment no. issued by **National Registry of ART clinics and Banks in India** of **ICMR** to Head clinic in given boxes.
 - b) Write the address (in capital letters) of Head clinic in space provided.
 - c) Fill the mobile no. of In-charge only in given boxes.

SECTION - II (MANPOWER)

“**Director**” should be a senior person who has had considerable experience in all aspects of ART. The director should be able to co-ordinate the activities of the rest of the team and take care of staff administrative matters, stock keeping, finance, maintenance of patient records, statutory requirements, and public relations as described in the ICMR ART guidelines.

22. Fill in the given box ‘1’ for Yes and ‘2’ for No.

23. Give the following details of qualification of the Director:

- **In column 2 of the table:** Write the highest qualification/degree in the space provided and also fill the proper code in the given box. The codes are :- ‘1’ for Ph.D./DM/M.Ch., ‘2’ for PG/MD/MS/DNB, ‘3’ for PG Diploma, ‘4’ for Diploma, ‘5’ for Graduate/MBBS and ‘6’ for Any other. In case of “Any other”, please specify in the given space.
- **In column 3 of the table:** Write the Area/Discipline in the space provided and fill in the given box ‘1’ for Medicine, ‘2’ for Life Sciences and ‘3’ for Any other. In case of “Any other”, please specify in the given space.
- **In column 4 of the table:** Fill in the given box ‘1’ for Regular and ‘2’ for Part-Time.
- **In column 5 of the table:** Fill the experience in infertility/ART (in yrs) in the given boxes. In case, experience is in years and months then take round off value in years (e.g. if the experience is more than & equal to 2 years 6 months then take round off value as 3 years and if value is less than 2 year 6 months then take round off value as 2 years).

“**In-charge**” means a person should be a trained gynecologist having appropriate degree as per ICMR ART guidelines and should conduct & supervise all the ART procedures at the ART clinic.

24. Fill in the given box ‘1’ for Yes and ‘2’ for No.

25. Give the following details of qualification of the In-charge:

- **In column 2 of the table:** Write the highest qualification/degree in the space provided and also fill the proper code in the given box. The codes are :- ‘1’ for DM/M.Ch., ‘2’ for MD/MS/DNB, ‘3’ for PG Diploma and ‘4’ for Any other. In case of “Any other”, please specify in the given space.
- **In column 3 of the table:** Write the Area/Discipline in the space provided and fill in the given box ‘1’ for Obst. & Gynecologist and ‘2’ for Any other. In case of “Any other”, please specify in the given space.
- **In column 4 of the table:** Fill in the given box ‘1’ for Regular and ‘2’ for Part-Time.
- **In column 5 of the table:** Fill the experience in area of ART (in yrs) in the given boxes. In case, experience is in years and months then take round off value in years (e.g. if the experience is more than & equal to 2 years 6 months then take round off value as 3 years and if value is less than 2 year 6 months then take round off value as 2 years).

26. Fill in the given box '1' for Yes and '2' for No.

27. Fill the number of Gynecologists in the given boxes.

28. Please give the details of qualification of Gynecologist:

- **In column 2 of the table:** Write the highest Qualification/degree in the space provided and also fill the proper code in the given box. The codes are :- '1' for DM/M.Ch., '2' for MD/MS/DNB, '3' for PG Diploma, '4' for Any other. In case of "Any other", please specify in the given space.
- **In column 3 of the table:** Write the Area/Discipline in the space provided and fill in the given box '1' for Obst. & Gynecologist and '2' for Any other. In case of "Any other", please specify in the given space.
- **In column 4 of the table:** Fill in the given box '1' for Regular and '2' for Part-Time.
- **In column 5 of the table:** Fill the experience in the area of ART (in yrs) in the given boxes. In case, experience is in years and months then take round off value in years (e.g. if the experience is more than & equal to 2 years 6 months then take round off value as 3 years and if value is less than 2 year 6 months then take round off value as 2 years).

Note: If you have more than three Gynecologists, please add separate sheets and fill accordingly.

29. Fill in the given box '1' for Yes and '2' for No.

30. Fill the number of Andrologists in the given boxes.

31. Please give the details of qualification of Andrologist:

- **In column 2 of the table:** Write the highest Qualification/degree in the space provided and also fill the proper code in the given box. The codes are:- '1' for Ph.D./DM/M.Ch., '2' for MD/MS/DNB, '3' for PG Diploma, '4' for Any other. In case of "Any other", please specify in the given space.
- **In column 3 of the table:** Write the Area/Discipline in the space provided and fill in the given box '1' for Urology, '2' for General Surgery and '3' for Any other. In case of "Any other", please specify in the given space.
- **In column 4 of the table:** Fill in the given box '1' for Regular and '2' for Part-Time.
- **In column 5 of the table:** Fill the experience in the area of Andrology (in yrs) in the given boxes. In case, experience is in years and months then take round off value in years (e.g. if the experience is more than & equal to 2 years 6 months then take round off value as 3 years and if value is less than 2 year 6 months then take round off value as 2 years).

Note: If you have more than three Andrologists, please add separate sheets and fill accordingly.

32. Fill in the given box '1' for Yes and '2' for No.

33. Fill the total number of Clinical Embryologists in given boxes.
34. Please give the details of qualification of Clinical Embryologist:
- **In column 2 of the table:** Write the highest Qualification/degree in the space provided and also fill the proper code in the given box. The codes are:- '1' for Ph.D./DM/M.Ch., '2' for PG/MD/MS/DNB/M.V.Sc., '3' for PG Diploma, '4' for Diploma, '5' for MBBS/B.V.Sc./B.Sc. and '6' for Any other. In case of "Any other", please specify in the given space.
 - **In column 3 of the table:** Write the Area/Discipline in the space provided and fill in the given box '1' for Medicine, '2' for Life Sciences, '3' for Veterinary Sciences and '4' for Any Other. In case of "Any other", please specify in the given space.
 - **In column 4 of the table:** Fill in the given box '1' for Regular and '2' for Part-Time.
 - **In column 5 of the table:** Fill the experience in the area of Embryology (in yrs) in the given boxes. In case if experience is in years and months then take round off value in years(e.g. if the experience is more than & equal to 2 years 6 months then take round off value as 3 years and if value is less than 2 year 6 months then take round off value as 2 years).

Note: If you have more than three Clinical Embryologists, please add separate sheet and fill accordingly.

35. Fill in the given box '1' for Yes and '2' for No.
36. Fill the number of Counselors in given boxes.
37. Please give the details of qualification of Counselor:
- **In column 2 of the table:** Write the highest Qualification/degree in the space provided and also fill the proper code in the given box. The codes are:- '1' for Ph.D./DM/M.Ch., '2' for PG/MD/MS/DNB, '3' for PG Diploma, '4' for Diploma, '5' for Graduate/MBBS and '6' for Any other. In case of "Any other", please specify in the given space.
 - **In column 3 of the table:** Write the Area/Discipline in the space provided and fill in the given box '1' for Social Sciences, '2' for Psychology, '3' for Life Sciences, '4' for Medicine and '5' for Any other. In case of "Any other", please specify in the given space.
 - **In column 4 of the table:** Fill in the given box '1' for Regular and '2' for Part-Time.
 - **In column 5 of the table:** Fill the experience in the area of counseling in ART (in yrs) in the given boxes. In case if experience is in years and months then take round off value in years (e.g. if the experience is more than & equal to 2 years 6 months then take round off value as 3 years and if value is less than 2 year 6 months then take round off value as 2 years).
38. Please fill the total number of staff members employed in your ART Clinic other than the staff specified above.
39. Please give the details of each staff:

- **In column 2 of the table:** Write the name of the post in the space provided and please do not fill the dotted boxes.
- **In column 3 of the table:** Write the highest Qualification/degree in the space provided and also fill the proper code in the given box. The codes are:- ‘1’ for Doctorate, ‘2’ for Post Graduate, ‘3’ for Graduate, ‘4’ for Diploma, ‘5’ for under Graduate and ‘6’ for Any other. In case of “Any other”, please specify in the given space.
- **In column 4 of the table:** Write the Area/Discipline in the space provided and fill in the given box ‘1’ for Medicine, ‘2’ for Nursing, ‘3’ for Life Sciences, ‘4’ for Social Sciences, ‘5’ for Psychology and ‘6’ for Any other. In case of “Any other”, please specify in the given space.
- **In column 5 of the table:** Fill in the given box ‘1’ for Regular and ‘2’ for Part-Time.
- **In column 6 of the table:** Please file the total number of the persons employed for that particular post.

Note: If you have more than 10 staff members then please add separate sheets and fill accordingly.

SECTION - III (INFRASTRUCTURE)

40. Fill in the given box ‘1’ for Yes and ‘2’ for No.
41. **From 41 (a) to (h):** Please fill in the given box ‘1’ for Yes and ‘2’ for No.
42. Fill in the given box ‘1’ for Yes and ‘2’ for No.
43. Fill in the given box ‘1’ for Yes and ‘2’ for No.
44. **From 44 (a) to (k):** Please fill in the given box ‘1’ for Yes, ‘2’ for No. In case of not applicable then enter ‘9’ in the given box (Here not applicable means that your ART Clinic does not have that particular procedure/facility).
45. **From 45 (a) to (hh):** Please fill in the given box ‘1’ for Yes and ‘2’ for No. In case of not applicable then enter ‘9’ in the given box (Here not applicable means that your ART Clinic does not has that particular procedure/facility).
46. Fill in the given box ‘1’ for Yes and ‘2’ for No. If No, then skip to Question no. **48**, otherwise continue.
47. **From 47 (a) to (n):** Please fill in the given box ‘1’ for Yes and ‘2’ for No.
48. Fill in the given box ‘1’ for Yes and ‘2’ for No.
49. Fill in the given box ‘1’ for Single Laboratory and ‘2’ for Multiple Laboratories. If ART clinic outsourcing from single Laboratory, then skip to Question No. **51**, otherwise continue.
50. Fill the total number of multiple laboratories in the given boxes from where your ART Clinic has got hormone assay facility.

51. Please fill the name of the outsourcing Laboratory in the space provided and distance (**in kms**) of the outsourcing Laboratories from your ART Clinic in the given boxes. Please do not fill the dotted boxes.
52. Fill in the given box '1' for Yes and '2' for No.
53. Fill in the given box '1' for Yes and '2' for No. If Yes, then skip to Question no. **56**, otherwise continue.
54. Fill in the given box '1' for Yes and '2' for No.
55. Please fill the distance (**in kms**) of the Specialty Laboratory from your ART Clinic in the given boxes.
56. Fill in the given box '1' for Yes and '2' for No.
57. Please specify the reason for microbiological laboratory not able to carry out rapid test for infection in the space provided (**Do not fill the dotted box**).
58. Fill in the given box '1' for Yes and '2' for No. If Yes, then skip to Question no. **61**, otherwise continue.
59. Fill in the given box '1' for Yes and '2' for No.
60. Please fill the distance (**in kms**) of the Specialty Laboratory from your ART Clinic in the given boxes.
61. Fill in the given box '1' for Yes and '2' for No. If Yes, then skip to Question no. **64**, otherwise continue.
62. Fill in the given box '1' for Yes and '2' for No.
63. Please fill the distance (**in kms**) of the Specialty Laboratory from your ART Clinic in the given boxes.
64. **From 64 (a) to (d)**: Please fill in the given box '1' for Yes and '2' for No.
65. Fill in the given box '1' for Yes and '2' for No.
66. Please specify the reason for not maintaining the records in the space provided and do not fill the dotted box.
67. **From 67 (a) to (d)**: Please fill in the given box '1' for Yes, '2' for No.
68. Fill in the given box '1' for Yes and '2' for No.
69. Fill in the given box '1' for Yes and '2' for No.
70. Fill in the given box '1' for Yes and '2' for No. If No, then skip to Question No. **72**.
71. Fill in the given box '1' for Yes and '2' for No.
72. **From 72 (a) to (j)**: Please fill in the given box '1' for Yes and '2' for No.
73. Fill in the given box '1' for Yes and '2' for No. If No, then skip to Question No. **75**.

74. **From 74 (a) to (d):** Please fill in the given box '1' for Yes and '2' for No and In case of "Others" please specify the source in the space provided.
75. Please specify the reason for not having appropriate provision for power backup in the space provided and do not fill the box.

SECTION - IV (PROCEDURES)

76. **From 76 (a) to (w):** Please fill in the given box '1' for Yes and '2' for No and in case of others please specify the ART procedure in the space provided.
77. Fill in the given box '1' for Yes and '2' for No.
78. **From 78 (a) to (f):** Please fill in the given box '1' for Yes and '2' for No.
79. (I) **Work-up**
- **From (a) to (b):** Please fill in the given box '1' for Yes and '2' for No.
- (II) **Male Factors**
- **From (a) to (f):** Please fill in the given box '1' for Yes and '2' for No.
 - **For Question No. b (II):** Please fill in the given box '1' for Routine Test, '2' for Culture Test (antibiotic sensitivity test) and '3' for Both.
- (III) **Female Factors**
- **From (a) to (p):** Please fill in the given box '1' for Yes and '2' for No.
 - **For Question No. d [I (v)]:** Please specify the drug used for ovulation induction in IUI in addition to above in the space provided and do not fill the dotted box.
 - **For Question No. d [II (vi)]:** Please specify the drug used for ovulation induction in IVF in addition to above in the space provided and do not fill the dotted box.
 - **For Question No. f (ii):** Please fill in the given box '1' for Routine Test, '2' for Culture Test (antibiotic sensitivity test) and '3' for Both.
- (IV) **Andrology**
- A. **Basic**
- **From (a) to (d):** Please fill in the given box '1' for Yes and '2' for No.
 - **For Question No. b:** Please specify the method for semen analysis followed other than WHO in space provided and do not fill the dotted box.
- B. **Advanced (sperm function test)**
- **From (a) to (c):** Please fill in the given box '1' for Yes and '2' for No.
80. Category of ART Clinic will be filled by the ICMR (**Please do not fill the dotted boxes**).
81. **From Question no. 81 (a) to (g)** will be filled by the ICMR (**please do not fill the information in the space provided and in the dotted boxes**).

Note: The Proforma should be duly signed by the Director or In-Charge of the ART Clinic along with the official seal/stamp on each page of the proforma and also in the space provided at the end.