GOVERNMENT OF MANIPUR
DIRECTORATE OF HEALTH SERVICES
...

ORDERS
Imphal, the 2nd September, 2026

No.MC/Conf-ICU/CCU/2025-DHS: In pursuance of the Government of Manipur, Secretariat: Health Department, Office Memorandum No. MED-1603/19/2023-HS-HEALTH dated 1st July, 2026 and subsequent orders regarding accreditation and standardisation of ICU services in the State, it is hereby ordered that separate inspection visits shall be undertaken to all private hospitals desirous of opening and registration of their ICU services.

2. The inspection team for each district shall comprise representatives of the State ICU Coordination Committee, ICU Implementation Unit and the concerned District ICU Inspection Committee. The inspection shall generally be led by the Chairman or the In-charge of the State ICU Coordination Unit, as designated by the competent authority.

3. All private hospitals desirous of obtaining accreditation of their ICU services shall submit their application in the prescribed form to the Directorate of Health Services, Manipur, on or before 20th September, 2026.

4. The inspection team shall assess the ICU facilities with reference to the prescribed standards, including infrastructure, equipment, manpower, oxygen facilities, essential drugs, operational readiness and other applicable requirements, and submit its assessment report to the State ICU Coordination Committee for consideration and further necessary action.

5. The concerned private hospitals shall extend full cooperation to the inspection team and make available all relevant records, documents and facilities required for assessment.

6. With effect from 1st December, 2026, no ICU shall be permitted to function without the requisite Government permission and certification/accreditation.

This Order shall come into force with immediate effect.

(Dr. N. Hemantakumar Singh)
Director of Health Services, Manipur

Copy to:

1. The Commissioner-cum-Secretary (Health & FW), Government of Manipur, for information.
2. The Joint Secretary (Health & FW), Government of Manipur, for information.
3. The Chairman, State ICU Coordination Committee, Manipur.
4. Dr. Y. Premchandra Singh, Additional Director (Planning & Finance) & SNO Tele-ICU, In-charge, State ICU Coordination Committee, for necessary action.
5. Senior Consultant ICU/Nodal Officer, , ICU, Trauma & Emergency Division, DHS, Manipur
6. ICU Consultants, ICU Implementation Unit, DHS, Manipur
7. All Chief Medical Officers/Chairpersons of District ICU Inspection Committees concerned.
8. All concerned private hospitals.
9. Office File.

GOVERNMENT OF MANIPUR
DIRECTORATE OF HEALTH SERVICES, MANIPUR
ICU, TRAUMA & EMERGENCY SERVICE DIVISION
APPLICATION-CUM-SELF ASSESSMENT FORM
FOR ACCREDITATION OF ICU SERVICES OF PRIVATE HOSPITALS

**To be submitted to:**
Directorate of Health Services, Manipur
**Last date for submission: 20th September 2026**

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## PART – A : DETAILS OF HOSPITAL

1. **Name of Hospital:** _____
2. **Complete Address:** _____

_____

3. **District:** _____
4. **Name of Hospital/Nodal Officer:** _____
5. **Designation:** _____ Mobile: _____
6. **Email:** _____
7. **Registration details of Hospital/Clinical Establishment:**
   Registration No. _____ Date: _____
8. **Total Hospital Bed Strength:** _____ beds
9. **Type of Hospital:**
   - ☐ General Hospital
   - ☐ Multi-speciality Hospital
   - ☐ Super-speciality Hospital
   - ☐ Other: _____
10. **ICU for which accreditation is sought:**
    - ☐ Level 1 ICU
    - ☐ Level 2 ICU
    - ☐ Level 3 ICU
11. **Total ICU Beds:** _____
12. **Date of commencement of ICU:** _____
13. **Average ICU occupancy during last 6 months:** _____ %
14. **Existing ICU accreditation/certification, if any:**
    ☐ NABH ☐ Other _____ ☐ Nil

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## PART – B : ICU SELF-DECLARATION / SELF-ENTRY

**Instruction:** The hospital shall enter the actual available status against each item and attach supporting documents wherever applicable.

| Sl. No. | Assessment area | Available/ Compliant | Not available/Non-compliant | Remarks / Details |
|---|---|---|---|---|
| 1 | Dedicated ICU area | | | |
| 2 | ICU bed strength | | | |
| 3 | Bed space/infrastructure as applicable to ICU level | | | |
| 4 | 24×7 emergency power / generator / UPS backup | | | |
| 5 | Oxygen supply system | | | |
| 6 | Suction/vacuum facility | | | |
| 7 | Electrical/UPS outlets | | | |
| 8 | Multiparameter monitors | | | |
| 9 | Ventilators | | | |
| 10 | Non-invasive ventilators | | | |
| 11 | Infusion pumps | | | |
| 12 | Syringe pumps | | | |
| 13 | Defibrillator | | | |
| 14 | Crash cart and emergency drugs | | | |
| 15 | Emergency oxygen cylinders | | | |
| 16 | ECG facility | | | |
| 17 | ABG facility | | | |
| 18 | Imaging services | | | |
| 19 | Laboratory services | | | |
| 20 | Pharmacy services | | | |

| Sl. No. | Assessment area | Available/ Compliant | Not available/Non-compliant | Remarks / Details |
|---|---|---|---|---|
| 21 | Blood bank/blood storage access | | | |
| 22 | Ambulance service | | | |
| 23 | Infection prevention and control | | | |
| 24 | Biomedical waste management | | | |
| 25 | Fire and safety systems | | | |
| 26 | Nursing station/monitoring facility | | | |
| 27 | ICU medical staffing | | | |
| 28 | ICU nursing staffing | | | |
| 29 | ICU duty roster | | | |
| 30 | Specialist/interdisciplinary consultation | | | |
| 31 | Medical records/documentation | | | |
| 32 | Equipment maintenance/AMC | | | |
| 33 | ICU admission/discharge policy | | | |
| 34 | Referral/transfer arrangements | | | |
| 35 | Tele-ICU facility/linkage, if available | | | |

## PART – C : MANPOWER SELF-ENTRY

### A. ICU Specialist/In-charge

| Name | Qualification | ICU experience | Full-time/Part-time | Professional time in ICU |
|---|---|---|---|---|
| | | | | |

### B. ICU Doctors

| Name | Qualification | ICU experience | Duty status | Shift |
|---|---|---|---|---|
| | | | | |

### C. ICU Nurses

| Total ICU nurses | Trained ICU nurses | Nurses per shift | Nurse-patient ratio |
|---|---|---|---|
| | | | |

### D. Allied/Support Staff

| Category | Sanctioned/Available | Trained/Qualified | Remarks |
|---|---|---|---|
| Technician | | | |
| Respiratory/other support | | | |
| Physiotherapy | | | |
| Dietician | | | |
| Other | | | |

## PART – D : EQUIPMENT SELF-ENTRY

| Equipment | Required as applicable to ICU level | Available | Functional | Remarks |
|---|---|---|---|---|
| ICU beds | | | | |
| Multiparameter monitors | | | | |
| Invasive ventilators | | | | |
| Non-invasive ventilators | | | | |
| Defibrillators | | | | |
| Infusion pumps | | | | |
| Syringe pumps | | | | |
| Portable suction | | | | |
| ECG machine | | | | |
| ABG analyser/access | | | | |
| HFNC | | | | |
| Transport ventilator | | | | |
| Transport monitor | | | | |
| Ultrasound | | | | |
| Emergency/crash cart | | | | |
| Other essential equipment | | | | |

## PART – E : SUPPORT SERVICES

Please indicate availability:

| Service | 24×7 Available | Available but not 24×7 | Not available | Remarks |
|---|---|---|---|---|
| Laboratory | ☐ | ☐ | ☐ | |
| ABG | ☐ | ☐ | ☐ | |
| Imaging | ☐ | ☐ | ☐ | |
| Pharmacy | ☐ | ☐ | ☐ | |
| Blood bank/blood access | ☐ | ☐ | ☐ | |
| Ambulance | ☐ | ☐ | ☐ | |
| Oxygen supply | ☐ | ☐ | ☐ | |
| Emergency referral | ☐ | ☐ | ☐ | |
| Infection control | ☐ | ☐ | ☐ | |

## PART – F : DOCUMENTS TO BE ENCLOSED

☐ Hospital registration certificate
☐ ICU registration/details
☐ ICU floor plan/layout
☐ ICU bed details
☐ Manpower statement and qualifications
☐ Duty roster
☐ Equipment inventory
☐ Equipment maintenance/AMC details
☐ Oxygen system details
☐ Ambulance details
☐ Laboratory/imaging support details
☐ Infection control arrangements
☐ Fire and safety compliance
☐ ICU admission/discharge policy
☐ Referral/transfer arrangements
☐ Existing accreditation/certification, if any
☐ Other relevant documents

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## PART – G : SELF-DECLARATION

I, , **being the authorised representative of** ..... Hospital , hereby certify that the information furnished in this application-cum-self assessment form is **true, complete and correct to the best of my knowledge**.

I understand that the information furnished shall be subject to verification by the **State ICU Coordination Committee, ICU Implementation Unit and representatives of the concerned District ICU Inspection Committee**.

I further undertake to comply with the applicable ICU standards prescribed by the **Ministry of Health & Family Welfare/DGHS, Government of India**, and the requirements prescribed by the Government of Manipur.

**Name:** _____

**Designation:** _____

**Signature:** _____

**Mobile No.:** _____

**Date:** _____

**Official Seal of Hospital**

_____

## PART – H : FOR OFFICIAL USE

**Date of receipt of application:** _____

**District:** _____

**Application complete:** ☐ Yes ☐ No

**District ICU Inspection Committee:**
☐ Recommended for State-level assessment
☐ Deficiencies communicated for rectification
☐ Not recommended

**Major observations:**

_____
_____

**Name & Signature of CMO/Chairperson, District ICU Inspection Committee**

Date: _____

**State ICU Coordination Committee / ICU Implementation Unit**

**Date of inspection:** _____

**ICU level assessed:** ☐ Level 1 ☐ Level 2 ☐ Level 3

**Recommendation:**
☐ Meets applicable requirements
☐ Meets requirements subject to rectification
☐ Does not meet requirements

**Final decision:** _____

**Signature of authorised officer:** _____

Date: