



KERALA NURSES AND MIDWIVES COUNCIL
RED CROSS ROAD,
THIRUVANANTHAPURAM - 35
INSPECTION PROFORMA FOR GNM PROGRAMME
Periodic Inspection
CHECK LIST FOR ANNEXURES

- | | |
|---|------------|
| I. Copy of Approved Orders | Yes / No |
| i. Indian Nursing Council | Yes / No |
| ii. Renewal of validity from INC for 2025-26 | Yes / No |
| c. State Nursing Council | Yes / No |
| II. List of faculty with details | Yes / No |
| Bio - data of faculty members | Yes / No |
| III. Details of Qualification, Experience, KNMC | } Yes / No |
| Registration and Salary Structure of
different categories of Nursing Staff | |
| IV. Copy of Clinical Affiliation Orders /Consent letters from hospitals | Yes / No |
| V. Copy of Affiliation Orders from DMO for Community Health Nursing | Yes / No |
| VI. Anti Ragging Committee / Squad | Yes / No |
| VII. Interaction with faculties (with photo) (interaction report if needed) | Yes / No |
| VIII. Interaction Report with students (with photo) | Yes / No |
| IX. Details of fee remitted for inspection | Yes / No |

Signature of inspector (1) ----- (2) -----



KERALA NURSES AND MIDWIVES COUNCIL
 RED CROSS ROAD,
 THIRUVANANTHAPURAM- 35

INSPECTION PROFORMA FOR GENERAL NURSING AND MIDWIFERY PROGRAMME
Academic Year:2026-27

INC School code: -----

Date of Inspection: -----

A GENERAL INFORMATION

1. Name of Institution : -----

2. Full Address with Pin Code : -----

3. School Opened on

D	D	M	M	Y	Y	Y	Y

4. First Batch Admitted on

D	D	M	M	Y	Y	Y	Y

G.N.M							
A.N.M							
Post Basic Diploma							

5. Batch to be admitted in 2026-27

G.N.M	A.N.M	Post Basic Diploma

6. Type of Inspection :

1.	First Inspection	<input type="checkbox"/>	4.	Surprise Inspection	<input type="checkbox"/>
2.	Annual Inspection	<input type="checkbox"/>	5.	Re- inspection	<input type="checkbox"/>
3.	Enhancement of seats	<input type="checkbox"/>	6.	Feasibility Study	<input type="checkbox"/>

7. Telephone Number of the Institution : ----- Fax No. -----

8. E-mail of the Institution : -----

9. Name of Principal : -----

Signature of inspector (1) ----- (2) -----

10. Telephone Numbers &

: (Residence) -----

: (Mobile) -----

email id of the Principal

: -----

11. Administrative Control

: 1. Government 2. Co-operative Sector
3. Missionary/Trust/Society 4. Autonomous

5. Any other - specify -----

12. Name of the Trust / Society

: -----

13. Name & address of M.D / Chairman

: -----

: -----

: -----

Telephone

: -----

Mobile

: -----

email – id

: -----

14. Sanctioned number of admissions per year:

Course	INC	KNMC
a.ANM		
b.GNM		
c. Post Basic Diploma		

15. Total number of students under training: –

A. GNM

Year	Male	Female	Total
I year			
II year			
III year			
Grand Total			

B.ANM

Year	Total
I year	
II year	
Grand Total	

C. Post Basic Diploma

Year	Male	Female	Total
I year			

D. Any other Courses and Total No. Students

Course	I Year - No. of Students	II Year - No. of Students	III Year- No. of Students	IV Year - No. of Students	Grand Total
B.Sc (N)					
M.Sc (N)					
Post Basic B.Sc (N)					

Signature of inspector (1) ----- (2) -----

6. Multipurpose Hall/Auditorium	3000 Sq: feet		
7. Library	1800 Sq: feet		
8. A.V. Aids Room	300 Sq:feet		
9. Common Room (Male& Female)	1000 Sq: feet		
10. Store room	300 Sq: feet		
11. Provisions for Toilets	1000 Sq: feet		

2. Laboratories

1	2		3	4	5	6	7
Laboratories	Size		Hand Washing facility	Articles / Equipment's	Manikins	Schedule if sharing	Remarks
	Minimum requirement	Available	Available	Adequate / Inadequate	Type & No.		
1. Nursing Foundation	1500 Sq: f.						
a. No. of beds	1:6						
2. CHN & Nutrition Lab	900 Sq: f.						
a. No. of CH bags	1:2						
3. Advance Nursing Skill Lab	900 Sq: feet						
4. OBG and Paediatrics	900 Sq: feet						
5. Pre-Clinical lab	900 Sq. feet						
6. Computer lab	1500 Sq.f.						
a. No. of Computers	1: 5						

3. Audio Visual Aids

	Available	Remarks
1. No. of charts		
2. No. of Models		
3. O.H.P		
4. L C D Projector		
5. Laptop		
Any other (specify)		

Signature of inspector (1) ----- (2) -----

4. Library

1. Separate library for School of Nursing	Yes / No	Remarks
2. Size (Area)		
3. Seating capacity		
4. Total No. of books		
5. Total No. of books Purchased during last year		
6. Total types of Journals		
National:		
International:		
7. Total types of Journals subscribed during last year		
8. Furniture	Adequate / inadequate	
9. Librarian's room	Yes/No	
10. Reading room	Yes/No	
11. Store room	Yes/No	
12. Photocopying facility	Yes/No	
13. Computer facility	Yes/No	
14. Internet facility	Yes/No	
15. Accession Register	Yes/No	
16. Issue Register		
Staff:	Yes/No	
Students:	Yes/No	

5. Water supply and sanitation

		Remarks
a. Safe drinking water facility	Yes/No	
b. Hand washing facility	Yes/No	
c. No. of Toilets Gents		
Ladies		

Signature of inspector (1) -----(2) -----

C. FACULTY POSITION

Sl. No	Teaching Faculty	Available	Remarks
1	Principal		
2	Vice – Principal		
3	Tutor		
	Total		
Teacher student ratio of 1:10 maintained: Yes / No			

* **Submit Bio data of each teaching faculty as per the proforma attached (ANX II)**

NB: Inspectors should verify all the Certificates of faculty to make sure that they are genuine.

OFFICE STAFF

Sl. No	Designation	Number Appointed	Remarks
1	Head Clerk		
2	U.D.C		
3	L.D.C		
4	Typist		
5	Accountant / Cashier		
6	Librarian		
7	Peon		
8	Watchman		
9	Sweeper		
10	Driver		

Salary Structure (with Bank statement)

1. Principal : -----
2. Vice – Principal : -----
3. Tutors : -----

Signature of inspector (1) -----(2) -----

D CLINICAL FACILITIES**1. Parent Hospital**

Name & Address of the Parent Hospital : -----
 : -----
 : -----
 Year of starting : -----

	Available	Remarks
Bed Strength of the Parent Hospital		
Total No. of Patients (on the day of inspection) (IP + OP)		
Average No. of patients in the previous month (IP only)		
Average O.P./day		
Bed occupancy (Total No.& Percentage)		
I.P Status on the day of inspection		
No. of Operation Theaters		
Major Operation per month		
Minor Operation per month		
No. of deliveries per month		
a. Normal		
b. Abnormal		

Is there any change in Bed strength from previous inspection: Yes/No (If yes please furnish details)

Distribution of Beds – Parent Hospital & Affiliated hospitals.

	Requirement	Available		Last month occupancy		Remarks	
		Parent Hospital	Affiliated Hospital	Parent Hospital	Affiliated Hospital	Parent Hospital	Affiliated Hospital
Medical	45						
Surgical	45						
Obstetrics & Gynecology	45						
Paediatric	30						
Ortho	15						
Psychiatric	50						

Signature of inspector (1) ----- (2) -----

Other specialities							
Major OT							
Minor OT							
Dental							
Eye /ENT							
Burns and Plastic							
Neonatology with Nursery							
Communicable diseases							
Emergency beds							
Cardiology							
Oncology							
Neurology / Neuro-surgery							
Nephrology							
ICU/ICCU							
Student – Patient ratio	1: 3						

Investigation Facilities – Parent Hospital

Lab Facilities and X-ray	Yes / No
USG	Yes / No
Echo	Yes / No
ECG	Yes / No
Tread Mill	Yes / No
C T Scan	Yes / No
MRI	Yes / No

Nursing Service Department - Parent Hospital

		Minimum Required	Available	remarks
1.	Nursing Superintendent	1: 200 beds		
2.	Deputy Nursing Superintendent	1: 300 beds		
3.	Ward Nursing Supervisors / Sisters	8: 200+30% leave Reserve		
4.	Staff Nurse for wards	1:3 (of 1: 9 each shift) +30% leave reserve		
5.	For OPD, Blood Bank, X-ray Diabetic Clinic CSR etc	1: 100 OPD Patients		
6.	For Intensive Care Unit	1: 1 (of 1: 3) for each		
7.	For specialized departments and clinic such as OT, Labour room	8:200 + 30 % leave reserve		
8.	Total Registered Nurses			
9.	ANM staff			

Signature of inspector (1) ----- (2) -----

3. Community Health Nursing

a. RURAL FIELD

Name of the CHC / PHC / SC

Adopted / Affiliated

Teaching responsibility of field staff ----- Yes / No

Supervision of students

- i) Field Staff only
- ii) Tutors and Clinical instructors only
- iii) Both

b. URBAN FIELD

a) Name of the MCH & FW Centre

i) Adopted / Affiliated

b) Teaching responsibility of field staff - Yes / No

c) Supervision of Students

- i) Field Staff only
- ii) Tutors and Clinical instructors only
- iii) Both

N. B Copy of all affiliation letters to be attached (ANX V)

(Inspectors to visit the hospitals and community health field and record their observations)

E CURRICULUM IMPLEMENTATION

1. Do you stick on to Curriculum plan - Yes / No

2. Pass percentage of students in Council Examination – 2025

GNM	No. of candidate appeared		No. of candidate passed		Percentage		Remarks
	Regular	Supply	Regular	Supply	Regular	Supply	
I Year							
II Year							
III Year							

ANM	No. of candidate appeared		No. of candidate passed		Percentage		Remarks
	Regular	Supply	Regular	Supply	Regular	Supply	
I Year							
II Year							

Signature of inspector (1) ----- (2) -----

Post Basic Diploma	No. of candidate appeared		No. of candidate passed		Percentage		Remarks
	Regular	Supply	Regular	Supply	Regular	Supply	
I Year							

F. RECORDS/REGISTERS IN THE SCHOOL OF NURSING

a) For Students	
1. Admission Record	Yes / No
2. Health record	Yes / No
3. Class attendance Register	Yes / No
4. Clinical and Field attendance Register	Yes / No
5. Clinical and Field experience Certificate	Yes / No
6. Internal mark register	Yes / No
7. Mark Lists (State Council /Board results)	Yes / No
8. Record for extracurricular activities of students (both in the school as well as outside)	Yes / No
9. Leave records	Yes / No
10. Practice record books – Procedure book and Midwifery record Book to be maintained by as prescribed by INC	Yes / No
b) For each academic year, for each class / batch	
1. Course contents records (for each subject)	Yes / No
2. The record of the academic performance	Yes / No
3. Rotation plans for each academic year	Yes / No
4. Record of committee meetings	Yes / No
5. Record of stock of the school	Yes / No
6. Affiliation records	Yes / No
7. Grant- in-aid record (if the school is receiving grant – in-aid from any source like State Govt. etc)	Yes / No
8. Cumulative record	Yes / No
9. Organization chart	Yes / No
10. Master rotation plan	Yes / No
11. Time Table	Yes / No
12. Course plan for each subject	Yes / No
13. Lesson Plan	Yes / No
14. Anti Ragging Committee / Squad	Yes / No

Signature of inspector (1) ----- (2) -----

15. Research Project report	Yes / No
16. Staff attendance register	Yes / No
17. Staff meeting minutes register	Yes / No
18. Annual report	Yes / No
19. PTA meeting minutes	Yes / No

****Inspectors are directed to submit the copy of the minutes of the meeting Anti Ragging Committee / Squad (ANX VI)***

G TRANSPORTATION

- No. of Vehicles -
- Vehicle Number -
 - Seating capacity -

H BUDGET

1. Is there a separate budget for the school	Yes / No
2. Was the budget utilized effectively for school	Yes / No
3. Audited Income and Expenditure Statement of last financial year	Yes / No

I. HOSTEL FACILITIES

Whether the School is having a separate hostel?	Yes / No
a) Area of the Hostel Sq. ft
b) Own / rented /leased	
c) Is there separate provision of hostel for Male and Female Students	Yes / No
d) Number of rooms	Girls: Boys:
e) Size of each room	
f) Lighting & Ventilation	Good / Poor
Total No. of students in the hostel	Girls: Boys:
No. of students allotted to each room	Girls: Boys:

Signature of inspector (1) ----- (2) -----

g. Room furniture allotted to each student	Adequate /Inadequate
h. No. of toilets and bathrooms	Adequate /Inadequate
i. Water facilities available	Yes / No
j. Hot water supply	Yes / No
k. Electricity facilities available	Yes / No
l. Adequate facilities for disposal of wastes	Yes / No
m. Recreation room available	Yes / No
n. Recreation facilities available:	TV/ Radio / Indoor / Outdoor games etc.
Any other:	
o. Separate Visitor's room with toilet facility	Yes / No
p. Dining room with hand washing facility	Yes / No
q. Kitchen and Pantry	Yes / No
r. Store room	Yes / No
s. Laundry	Yes / No
t. Warden's room	Yes / No
u. Mess arrangements to own institution	Yes / No If 'No' specify alternative arrangements

HOSTEL STAFF

Sl. No	Designation	Number Appointed	Remarks
1	Warden		
2	Assistant Warden		
3	House keeper (Female)		
4	Cooks		
5	Sweeper		
6	Watchman		

Signature of inspector (1) ----- (2) -----

Inspection Report

A. Strong Points:

1. School:

2. Library:

3. Laboratories:

4. Faculty:

5. **Clinical facilities:**

6. **Hostel:**

7. **Records and Registers:**

B. **Deficiencies:**

1. **School:**

2. **Library:**

3. **Laboratories:**

4. **Faculty:**

5. **Clinical facilities:**

6. **Hostel:**

7. **Records and Registers:**

Suggestions:

- ❖ We hereby affirm that, to the best of my knowledge, the information provided is true and accurate. This statement serves as a representation of my commitment to honesty and integrity. We understand that any deliberate misrepresentation of the information provided may result in legal consequences. Therefore, we have taken utmost care to ensure that the information provided is free of errors and presented in a clear, concise manner.
- ❖ Inspectors shall be liable for any misrepresentation or deceitful information included in the inspection reports

*** Please ensure that all columns and rows are filled and all details and information are furnished in the Inspection Proforma before forwarding to Kerala Nurses and Midwives Council.**

Sl. No.	Name and address of Inspector with contact Number and Email id	Signature
1		
2		

Date of submission of Report:

Details of Regular Teaching Faculty of all Nursing programme offered by the Institution

Sl. No	Name	Designation	Age & Date of Birth	Qualification		Name of the Institute from where qualified	Name of the University	
1.				a.				
				b.				
				c.				
	Year of passing		Speciality	Total Years of Experience			Date of Joining in the present institution	Please affix a self-attested stamp size photograph
				Clinical	Teaching			
	a.				Before PG	After PG		
	b.							
		c.						
	RN, RM No. Date of Registration:..... Date of Renewal:Date of Regn. of Addl. Quali.....							
	Verified original certificates Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Specify reason							
Sl. No	Name	Designation	Age & Date of Birth	Qualification		Name of the Institute from where qualified	Name of the University	
2.				a.				
				b.				
				c.				
	Year of passing		Speciality	Total Years of Experience			Date of Joining in the present institution	Please affix a self-attested stamp size photograph
				Clinical	Teaching			
	a.				Before PG	After PG		
	b.							
		c.						
	RN, RM No. Date of Registration:..... Date of Renewal:Date of Regn. of Addl. Quali.....							
	Verified original certificates Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Specify reason							

Signature of inspector (1) -----

(2) -----

