



**KERALA NURSES AND MIDWIVES COUNCIL
RED CROSS ROAD,
THIRUVANANTHAPURAM – 35**

Inspection Proforma for establishing New Nursing Educational Institutions in Kerala

Basic Information:

Name and address of the proposed College	
Nursing programme (s) under inspection	
1) B Sc (N) <input type="checkbox"/>	2) P B B Sc (N) <input type="checkbox"/> 3) M Sc (N) <input type="checkbox"/> (Specify specialty)

Academic year for which NOC is requested at present:

Number of seats requested:

Details of fee remitted for inspection (Annexure XV1)

Any previous KNMC inspection: Yes/No

Last rectification report of Govt of Kerala (if applicable)

Present inspection : First/Second/Third

KERALA NURSES AND MIDWIVES COUNCIL
RED CROSS ROAD,
THIRUVANANTHAPURAM - 35
INSPECTION PROFORMA FOR COLLEGIATE PROGRAMMES
CHECK LIST FOR ANNEXURES

(Starting New College)

			Remarks
Annexure I	Approval / Sanction orders of the Government	Yes / No	
II	Certified copy of the Trust Registration Document	Yes / No	
III	Philosophy	Yes / No	
IV	Organizational Chart	Yes / No	
V	Copy of Land Deed with Ownership Certificates and receipt of land tax	Yes / No	
VI	Approved Building Plans for College and Hostel	Yes / No	
VII	List of items available in each lab	Yes / No	
VIII	Purchase order of articles of Community Health Nursing, Maternal and Child Health Nursing Lab	Yes / No	
IX	List of books & journals	Yes / No	
X	Appointment order/ willingness letter from faculty	Yes / No	
XI	Proof of Parent Hospital	Yes / No	
XII	Clinical affiliation orders and MOU	Yes / No	
XIII	Affiliations in the Parent Hospital, MOU	Yes / No	
XIV	Details of vehicle	Yes / No	
XV	Budget	Yes/ No	
XVI	Details of fee remitted for inspection	Yes / No	
Proforma I	Bio –data of faculty	Yes/No	
II	List of RN-RM & ANM’s of Parent & Affiliated Hospitals	Yes/No	
III	Faculty photo with inspectors	Yes/No	

Signature of Inspectors: 1.

2.



KERALA NURSES AND MIDWIVES COUNCIL

RED CROSS ROAD,
THIRUVANANTHAPURAM- 35

INSPECTION PROFORMA FOR COLLEGIATE PROGRAMMES (Starting New College)

Academic Year: 2026-27

Date of Inspection: -----

I GENERAL INFORMATION

1. Name of the proposed Institution : -----
(In Capital Letters) -----

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

3. Nursing Programme
under Inspection:

- | | | | |
|--|--------------------------|-------------------------|--------------------------|
| 1. Basic B. Sc. (N) | <input type="checkbox"/> | 2. Post Basic B.Sc. (N) | <input type="checkbox"/> |
| 3. PB Diploma
in Speciality Nursing | <input type="checkbox"/> | 4. M.Sc. (N) | <input type="checkbox"/> |
| 5. GNM | <input type="checkbox"/> | | |

4. Academic Year for which approval is requested at present:

5. Number of seats requested:

Approval / Sanction order of the Government (Annexure I)

6. Any previous inspection: Yes/No

7. Last rectification report (if applicable)

8. Present inspection : First/Second/Third

9. Administrative Control : 1. Government 2. University
3. Missionary/Trust/Society 4. Autonomous

5. Any other - specify

10. Name of the Trust/Society/Missionary/ Company: -----

Certified copy of the Trust Registration Document - Annexure - II

11. Philosophy (Attach copy) Yes / No - **Annexure - III**
12. Organization Chart (Attach copy) Yes / No - **Annexure - IV**

Signature of Inspectors: 1.

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II. PHYSICAL FACILITIES

❖ College

- | | | | |
|-------------------------|--------------------------|------------------------|--------------------------|
| 1. Owned | <input type="checkbox"/> | 2. Rented | <input type="checkbox"/> |
| 3. Leased | <input type="checkbox"/> | 4. Independent | <input type="checkbox"/> |
| 5. Attached to Hospital | <input type="checkbox"/> | 6. Any other – Specify | |

- | |
|---|
| <ul style="list-style-type: none"> • Copy of Land Deed with Ownership Certificates and receipt of land tax- Annexure V • Approved Building Plans for College and Hostel - Annexure VI |
|---|

Facilities	Minimum requirement as per INC norms (60 intake)	Available	Remarks
A. Teaching block			
a. Area of land	3-4 Acres		
b. Built up area of the College building	23720 Sq:ft		
c. Lecture Halls No.	4 for B.Sc N & extra /batch		

Area/Size	1080 Sq:ft		
No. of Tables			
No. of chairs	Adequate for intake		
B. Examination Hall			
1. Area	3000 Sq:ft		
2. Seating capacity	-----		
3. Confidential Room	} Exam. Purpose	Yes /No	
4. CCTV facility, Mobile Jammer		Yes /No	
5. Furniture	Adequate for capacity		
C. Laboratories (6 labs)			
a) Nursing Foundation Lab	1500 Sq:ft		
1. No. of beds	1:6 students		
2. No. of articles	10-12 sets		
3. Equipment & Supplies	Adequate for lab practice		

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4. No. of dummies	4-5 Adult manikin - 2 Multi Functional Patient care maniquin -1 CPR maniquin – 1 IV arm - 1		
5. Hand washing facilities	Elbow /Leg operated system		
b) Nutrition Lab - Area	900 Sq.ft		
1. Equipment & Supplies	Adequate for practice		
2. Charts / models	Adequate for practice		
c) MCH Lab – Area	900 Sq.ft		
Simulators/charts/models/play materials /specimens. Charts / models/specimens	Birth Simulator - 1 Child / neonate - 1		

Annexure VII - List of items available in each lab

Annexure VIII- Purchase order of articles of Community Health Nursing, Maternal and Child Health Nursing Lab

d) CHN Lab - Area	900 sq.ft		
Charts / models etc Community Health Bags	1:2 students		
e) Computer Lab No. of Computer } Internet facilities }	1500 sq.ft 1:5		
f) Pre-Clinical Science Lab	900 sq.ft		
D. A.V. AIDS Room OHP	600 sq.ft 1 for each class room		
LCD/DLP	2 (minimum)		
TV/Video	1		
Charts /models /specimen Other T-L aids specify	Adequate for each subject		

Signature of Inspectors: 1.

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E. Library	Minimum required	Available	Remarks
Library Area	2400 Sq.ft		
Seating Capacity	Min.60		
Staff reading room	10 persons		
Room for librarian			
Furniture	Adequate		
No. of cupboards			
No. of racks	Adequate		
Standard reference books as per Syllabus available			
▪ Total number of Nursing journals available			
▪ National			
▪ International			

• Photocopying facility	Yes /No	
• Internet facility	Yes /No	
• Separate section for staff / PG	Yes /No	
• Ventilation	Adequate/ Inadequate	
• Lighting	Adequate /Inadequate	

Any other – Specify:

Annexure IX (a)-List of books/purchase order) (b) Attach list of journals / purchase order (c)Appointment order/Undertaking of library staffs

F. Water supply and sanitation

Safe drinking water facility Yes No

Hand washing facility Yes No

No. of toilets in the college Gents Ladies

Proper waste management system Yes No

Signature of Inspectors: 1.

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G. Office & Faculty Rooms

Administrative Facilities	Minimum Area in sq.ft	Available	Remarks
Office of the Principal with visitors room	300		
Vice Principal	200		
Professor	200		
Asso. Prof	200		
Asst. Professor	200		
Lecturer/ Tutor's room	200		
Offices of Admin. Clerical staff and PA(s)	1000		
Accountant's office			
Store Room Record room			
Duplicating/Xeroxing room			
Common room with all facilities } <ul style="list-style-type: none"> • Girls • Boys • Staff 	3		
Multipurpose Hall /Auditorium Seating Capacity			

H. Other facilities: Hall for indoor games, Playground, Garage, Fire escape facility etc.

(Inspectors are requested to verify all the facilities)

Signature of Inspectors: 1.

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III. TEACHING FACULTY

Sl. No	Designation	Med. Surg Nursing	OBG Nursing	Paed. Nursing	Psy. Nursing	CH Nursing	Total
1	Principal						
2	Vice Principal						
3	Professor						
4	Asso. Professor						
5	Asst. Professor						
6	Tutor/ Lecturer						
	TOTAL						

Annexure X- Appointment order/ willingness letter from faculty

Signature of Inspectors: 1.

2.

Details of Nursing Teaching Faculty

Sl. No	Name	Designation	Age & Date of Birth	Qualification	Name of the Institute from where qualified	Name of the University
				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
				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 Inspectors: 1.

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External Teachers

Sl. No	Name of faculty	Designation	Qualification	Subject taught	Remarks
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Signature of Inspectors: 1.

2.

OFFICE STAFF

Sl. No.	Designation	Minimum Required	No. available	Remarks
1	Administrative Officer /Office Superintendent	1		
2	C A to Principal	1		
3	U.D.C	2		
4	L.D.C	2		
5	Accountant-cum-cashier	1		
6	Librarian grade IV	2		
7	Attender	1 for Library 1 ,, Lab 1 ,, Office		
8	Watchman	2		
9	Driver	2		
10	Peon	1		
11	Cleaner (Bus)	1		
12	Sweeper	2		

IV. CLINICAL FACILITES OF PARENT AND AFFILIATED HOSPITALS**A. PARENT HOSPITAL**

Parent Medical College Yes No

Parent Hospital Yes No

Sl. No	Name & address of the Parent hospital	Number of Beds	Average No. of inpatient for the last month	No. of Schools affiliated	No. of Colleges affiliated	Distance from the College in kms	No. of Registered Nurses
1							

Proof of Parent Hospital (If needed) - Annexure XI

Signature of Inspectors: 1.

2.

CLINICAL AREAS IN THE PARENT HOSPITAL

CLINICAL AREAS	Minimum Required	No. of beds available	No. of inpatients on the day of inspection	Average no. of inpatient for the last month
Medical	40			
Surgical	40			
Paediatrics	30			
Gyne & Obst.	40			
Orthopaedic	10			
ICU (Medical,Surgical and Specialities)	Specify available facilities			

Eye, ENT	10			
Coronary /ICCU /ICU	5-10			
Nephrology	10			
Neurology	10			
Trauma care Unit	10			
Burns and Plastics	5-10			
Oncology	5-10			
Dermatology	5-10			
Psychiatry				
Cardio Thoracic	Specify facility available			
Neuro ICU				
Neonatal ICU				
TOTAL				
Emergency/ Casualty				
Dialysis/ Day care				

Signature of Inspectors: 1.

2.

B. AFFILIATED HOSPITALS: Total No. of Affiliated Hospitals (Max-3, only for specialties) :

DETAILS OF AFFILIATED HOSPITALS:

Sl. No	Name & Address of the Affiliated Hospitals	Distance from the College in kms	Clinical speciality for which affiliation is sought	Year & Batch of Programme	No. of beds in respective speciality	No. of Colleges /Schools affiliated		No. of Registered Nurses	Remarks
						Schools	Colleges		
1									
2									
3									

Signature of Inspectors: 1.

2.

C. Other Clinical Areas

Sl.No.	Areas	Parent Hospital	Remarks			
			1	2	3	
1	No. of Operation Theatres					
	Major OT					
	No, of Tables					
	Minor OT					
2	Average No. of Operations per month					
	Major					
	Minor					
3	Average No of deliveries per month					
4	No. of outpatient on the day of inspection					
5	No. of inpatients on the day of inspection					
6	Average no. of inpatient for the last six months					

D. NURSING SERVICE DEPARTMENT

Sl. No	Designation	No. Available in Hospitals			Remarks
		Parent	Affiliated		
			1	2	
1	Chief Nursing Officer/ Nursing Superintendent				
2	Deputy Nursing Superintendent				
3	Head Nurse				
4	Staff Nurse				
5	ANMs				

Supporting Staff

Nursing Assistants -

Class IV employees -

Signature of Inspectors: 1.

2.

E. Hospital Records & Registers

Records/Register	Available	Remarks
IP Register	Yes/No	
OP Register	Yes/No	
Day / Night Report	Yes/No	
Discharge Register	Yes/No	
Census	Yes/No	
Any other (specify)		

Suitability of affiliated hospital for student's training : Yes / No

Details of other affiliated hospitals (if more than three)-

Annexure XII - Clinical affiliation orders and MOU

F. INSTITUTIONS AFFILIATED TO THE PARENT HOSPITAL

Name of the School / College	Academic Year	Nursing Programme	Clinical Specialty for which affiliation given	No. of Students	Duration of Posting

Annexure XIII - Affiliations in the Parent Hospital, MOU

*** Inspectors are requested to verify all Records/Register and document the remarks.**

Signature of Inspectors: 1.

2.

G. COMMUNITY HEALTH FACILITIES - (Enter details only if arrangements are made)

Details	Rural Field	Urban Field
Name of CHC/PHC/MCH/FW Centre		
Adopted / Affiliated		
Details of PHC/CHC/Centre		
Distance from college (in km):		
Area coverage (in km):		
Population coverage:		
Supervision of students: by field staff/College faculty / Both		

V. TRANSPORTATION

No. of vehicles available	-
Vehicle No.	-
Seating capacity	-
Staff car for Principal	- Yes <input type="checkbox"/> No <input type="checkbox"/>

**Annexure XIV – (a) Details of Vehicles(Purchase Order)
(b) Appointment order / Undertaking from Driver**

Signature of Inspectors: 1.

2.

VI. TEACHING PLAN

A. TEACHING PLAN FOR EACH PROGRAM/ BATCH

Teaching Plan	Available	Remarks
1. Master Plan	Yes /No	
2. Time table	Yes / No	
3. Clinical Rotation Plans	Yes / No	
4. Clinical Rotation is based on the syllabi and Clinical Learning Needs	Yes / No	
5. Nursing Service is consulted before planning	Yes / No	

*** Inspectors are requested to verify all Records/Register and document the remarks.**

VII. AVAILABILITY OF RECORDS / REGISTERS / REPORTS

A. Student Records

Name of Register	Availability	Remarks
a. Admission Register	Yes/No	
b. Attendance Register Students Teaching faculty Non- teaching staff	Yes/No	
c. Health Record	Yes/No	
d. Leave Record	Yes/No	
e. Cumulative record of each student	Yes/No	
a. Affiliation records	Yes/No	
b. Stock Register	Yes/No	
c. Mark Register	Yes/No	

*** Inspectors are requested to verify all Records/Register and document the remarks.**

Signature of Inspectors: 1.

2.

VIII. HOSTEL FACILITIES

1. College has a separate Hostel: : Yes No
2. Built-up area of the hostel (30750Sq.ft) : -----sq. ft.
3. Distance to hostel from the college (in kms) :
4. Ownership of the hostel : Own Rented Leased
5. Separate Hostel for Male and Female Students : Yes No.

Remarks if any-,

Dwelling area (50 sq.ft / student)	Rooms					Remarks
	Single	Double	Triple	Four	More than Four	
Girls :(no of rooms)						
Area per room (in sq.ft):						
Boys :(No of rooms)						
Area per room (in sq.ft):						

6. Dining Hall facilities:

			Remarks
a.	Dining hall well maintained	Yes/No	
b.	Size -----	Seating capacity -----	
c.	Hand washing facility	Yes/No	
d.	Safe drinking water facility	Yes/No	
e.	Hygienic kitchen	Yes/No	

7. General condition of the hostel

1. V Good 2. Good . 3. Average 4 Satisfactory 5. Poor

Signature of Inspectors: 1.

2.

8. HOSTEL STAFF

Sl. No.	Designation	Posts Required	Staff Appointed	Remarks
1	Warden	1		
2	Asst. warden			
3	House Keeper (F)	3(3 shifts)		
4	Cook(1: 20/shift)	3 for 60 students /shift		
5	Watchman	3		
6	Cleaning staff	3		

*** Inspectors are requested to visit the hostel and document the remarks.**

IX. BUDGET

1. a. Separate budget for the College Yes No

b. Amount per annum :

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Annexure - XV Copy of Budget

Name and address of Principal	Contact number	Email ID

Signature of Inspectors: 1.

2.

Inspection Report

A. Strong Points:

1. College:

2. Library:

3. Laboratories:

4. Faculty:

5. Clinical facilities:

6. Hostel:

7. Records and Registers

Signature of Inspectors: 1.

2.

B. Deficiencies:

1. College:

2. Library:

3. Laboratories:

4. Faculty:

5. Clinical facilities:

6. Hostel:

7. Records and Registers

Signature of Inspectors: 1.

2.

Suggestions :

*** Please ensure that all columns and rows are filled and all details and informations 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:

Signature of Inspectors: 1.

2.

KERALA NURSES AND MIDWIVES COUNCIL

PROFORMA - I

Bio –data of Teaching Faculty

1	Name	:	
2	Designation	:	
3	Age & Date of birth	:	
4	Permanent address	:	
5	Email id	:	Mobile No:
6	Date of joining this institution:		
Salary: Basic Pay:.....Allowances:.....Total:.....			

7. Professional Qualification

Sl. No	Programme	Name of Institution/University	Year of passing	Speciality
1	B.Sc. (N)/ PB B.Sc (N)			
2	M.Sc (N)			
3	Additional Qualification if any			

8. Registration Details

a.	KNMC Registration Number	:	Date:
b.	Date of Renewal of Registration	:	
c.	Date of Registering Additional Qualification:		

9. Experience

a. Clinical

Sl. No	Designation	Name of Institution	Date of joining	Date of leaving	Total Years

b. Teaching Experience

i. Before M.Sc. (N)

Sl. No	Designation	Name of Institution	Date of joining	Date of leaving	Total in years & months

ii. After M.Sc. (N)

Sl. No	Designation	Name of Institution	Date of joining	Date of leaving	Total in years & months

10. Summary of experience

Sl. No	Experience				Total
1.	Clinical Experience				
2.	Teaching Experience before PG				
3.	Teaching Experience after PG				
4.	Experience of Teaching				
	SON	CON	B.Sc.(N)	M.Sc.(N)	
GRAND TOTAL					

Declaration

I -----do here by declare that the information furnished by me in this proforma is correct and true. If any information is incorrect or false disciplinary action can be taken against me.

Date: _____ Signature of the faculty

Place: _____ Counter signature by Principal

(Seal)

Name of Principal:

Signature :

Signature of Inspectors: 1.

2.

