

FORM VI
See Rule II (I)

FORM FOR REGISTRATION AS SERVICE PROVIDERS UNDER SECTION 10(1) OF THE
PROTECTION OF WOMEN FROM DOMESTIC

VIOLENCE ACT, 2005

1. Name of applicant :
2. Address along with phone number :
e-mail address if any :
3. :Services being rendered : Shelter
: Psychiatric counselling
: Family counselling
: Vocational Training Centre
: Medical Assistance
: Awareness programme
Counselling for a group of people who are
victims of domestic violence and family
disputes
: Any other, specify
4. Number of persons employed :
for providing such services :
5. Whether providing the required services in
your institution required certain statutory :
minimum professional qualification? If yes
specify and give details
6. Whether list of names of persons and the
Capacity in which they are working and their : Yes/No
Professional qualification is attached?
7. Period for which the services are being
Rendered : 3 years
: 4 years
: 5 years
: 6 years
: More than 6years
8. Whether registered under any law/
Regulation : Yes/No
If Yes, give the Registration Number :
9. Whether requirements prescribed by any
regulatory body or law fulfilled? : Yes/No
If Yes, the name and address of the
Regulatory body

Note:- In case of a shelter home, details under column 10 to 18 are to be entered by registering authority after inspection of the shelter home.

10. Whether they in adequate space in the Shelter home : Yes/No
11. Measured area of the entire premise :
12. Number of rooms :
13. Area of the rooms :
14. Details of security arrangement available :
15. Whether a record available for maintaining functional telephone connection for the use of inmates for the last 3 years :
16. Distance of the nearest dispensary clinic Medical facility
17. Whether any arrangement for regular visits By a medical professional has been made? : Yes/No
- Professional :
- Address :
- Contact number :
- Qualification :
- Specialization :

18. Any other facilities available Specify

Note:-In case of a counselling centre, details under column 19 to 25 are to be entered after inspection by registering authority. :

19. Number of counsellors in the centre :
20. Minimum qualification of the counsellors, specify

- Under graduate Graduate Post graduate
- Diploma holder Professional Degree
- Any other, specify

21. Experience of the counsellors

- Less than a year 1 Year 2 years
- years more than 3 years

22. Professional qualification/experience of counsellors Professional degree

Experience in family counselling as adesignation in the(Name of the organization)

Experience in psychiatric counselling as(designation.....) in
the(name of the organization)
Any other relevant experience, please specify

23. Whether a list of names of counsellors along with their qualification has been annexed
Yes/No

24. Type of counselling provided:
Supportive one-to-one counselling
Cognitive behavioural therapy (CBT) (Mental process that people use to remember reason, solve
problems and judge things)
Providing counselling to group of people suffering
Family counseling

25. Facilities provided

Offering personal professional and confidential counselling sessions
A safe environment to discuss problems and express emotions
Information on counselling services support groups and mental health care resources
One-to-ne counselling and group work
Therapies, ongoing counselling and health related support
Any other please, specify

C Any other service

- (1) Services being provided
- (2) Personnel appointed
- (3) Statutory minimum qualifications required for providing such service
- (4) Whether a list of names of Personnel engaged for providing service along with professional qualification is annexed

Yes No

(5) Any other details which the service provider desirous of registration may provide
.....If necessary continue on a separate sheet.

Place
Date

Signature of authorised official
Designation

(Seal)