उत्तर प्रदेश आयुर्विज्ञान विश्वविद्यालय

सैफई, इटावा (उ0प्र0) – 206 130

सं0: 139 / यूपीयूएमएस / सी0एम0एस0(25) / 2026–27 दिनांक: 23 मई, 2026

ई–मेल / व्हाट्एप ग्रुप

सेवा में,

समस्त विभागाध्यक्ष, क्लीनिकल,
उ0प्र0 आयुर्विज्ञान विश्वविद्यालय,
सैफई, इटावा।

महोदय,

आपको अवगत कराना है कि कार्यालय आदेश संख्याः 16 / यूपीयूएमएस / सीएमएस(25) / 2025 –26 दिनांक 10.04.2026 द्वारा चिकित्सालय में भर्ती निराश्रित, बेसहारा एवं लावारिस मरीजों के पुनर्वास हेतु गठित समिति द्वारा एस0ओ0पी0 तैयार कर उपलब्ध करा दी गयी है।

उक्त तैयार एस0ओ0पी0 को मा0 कुलपति महोदय के अनुमोदनोंपरान्त, तत्काल प्रभाव से चिकित्सालय में लागू किया जाता है।

संलग्नक–एस0ओ0पी0।

(प्रो0 (डा0) एस0पी0 सिंह)
मुख्य चिकित्सा अधीक्षक

प्रतिलिपिः निम्नलिखित को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित–

1. कुलसचिव।
2. चिकित्सा अधीक्षक।
3. उप चिकित्सा अधीक्षक–01 एवं 02, ट्रामा एवं इमरजेंसी।
4. प्रभारी–वेबसाइट को इस आशय से प्रेषित कि पत्र के साथ संलग्न एस0ओ0पी0 को विश्वविद्यालय की वेबसाइट पर अपलोड करने का कष्ट करें।
5. मुख्य चिकित्सा अभिलेख अधिकारी।
6. प्रमुख निजी सचिव को, मा0 कुलपति महोदय के अवलोकनार्थ।
7. प्रमुख निजी सचिव, चिकित्सा अधीक्षक (हॉस्पिटल बोर्ड हेतु)।
8. कार्यालय प्रति।

(प्रो0 (डा0) एस0पी0 सिंह)
मुख्य चिकित्सा अधीक्षक

1. INTRODUCTION:

This Standard Operating Procedure (SOP) is established to ensure the systematic care, rehabilitation, and welfare of unknown and destitute patients admitted to Uttar Pradesh University of Medical Sciences The primary objective is to provide these patients with appropriate care and facilitate their rehabilitation while safeguarding the hospital's legal and institutional interests.

Uttar Pradesh University of Medical Sciences, focuses on helping unknown and destitute patients transition from hospital care to a safe and supportive environment. Rehabilitation means restoring a patient's health and well-being by ensuring they have access to basic needs like healthcare, shelter, and emotional support. For patients who have no family or resources, this process is essential to ensure they are not left vulnerable after discharge.

2. DEFINITION OF A DESTITUTE PATIENT IN HOSPITAL SETTING

Any homeless person who is found without any known identity and unable to take care of themselves, seeking medical care in UPUMS is considered as a destitute.

TERM	DEFINATIONS (WITH STATUTORY SOURCE)
Destitute Patient	A person who: (a) has no identifiable family/guardian; (b) has been abandoned; (c) has no fixed residence; (d) lacks financial means for treatment. Entitled to free treatment at Govt. MHEs - MHCA 2017, Sec. 18(7).
Mental Illness (MI)	Per Sec. 2(s) MHCA 2017: 'A substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.' Does NOT include mental retardation/intellectual disability.
Intellectual Disability (ID)	Explicitly EXCLUDED from definition of Mental Illness under Sec. 2(s) MHCA 2017. ID is a scheduled disability under RPWD Act 2016 (Schedule entry 14). Governed by RPWD Act 2016 and National Trust Act 1999.
Nominated Representative (NR)	Person appointed to support treatment decisions for a PMI per Sec. 14 MHCA 2017. For destitute patients, default NR = Director, Dept. Social Welfare (Sec. 14(4)(e)). Temporary NR = Rep. of Societies Reg. Act NGO (Sec. 14(4) Proviso).
MLC (Medico-Legal Case)	Any case involving injury, poisoning, suspected foul play, or unknown identity that has legal implications. All destitute/unknown patients must be registered as MLC and police notified.
MHRB	Mental Health Review Board - district-level quasi-judicial body constituted under MHCA 2017, Sec. 73-84. Reviews involuntary admissions and protects patient rights.
HPMI	Homeless Person with Mental Illness - a person found wandering or destitute who has a diagnosable mental illness per Sec. 2(s) MHCA 2017.

This SOP serves as a step-by-step guide to ensure a smooth and structured process, from assessment to transfer. It explains eligibility criteria, required documentation, and collaboration with NGOs and other authorities to provide the best care for these patients.

3. Admission, Treatment and Rehabilitation Protocol:

i. Immediate lifesaving care to be provided.

[MHCA 2017.SEC 94(1) any, medical treatment including for mental illness, may be provided by any registered medical practitioner to a PMI where it is immediate necessary to prevent death or irreversible harm;

SEC 21 (1): Emergency care for MI must be of the same quality and availability as for physical illness. No patient may be refused emergency care on grounds of destitute, unknown identity, or inability to pay].

ii. Dual initial assessment: Physical examination by the casualty medical officer- assess for injuries, infections, malnutrition, pressure sores, parasitic infestations.Psychiatric screening by the duty psychiatry resident or on call MHP- To determine if the patient presents with features of mental illness as defined by sec .2(s)MHCA 2017.

iii. Admission in concern department and Register as MLC case. Mention complete detail of brought by, Time, date, mode of transport and referral hospital detail if any. Attach referral slip in file. Send police information. MLC and police information to be done by on duty medical officer.

iv. Send police information and mention DD No and I.O. name in file.

v. Required treatment to be ensured by treating consultant.

vi. General care to be ensured by ANS and monitored by DNS/NS.

vii. All investigations, Treatment and Admission file made free on recommendation of MS/ On-duty EMO.

viii. All belongings to be sealed (If he/she is not able to carry) by on duty staff and handed over to ANS (Triage), If attendant come than handover to attendant otherwise handover to Police

ix. Consent for procedure to be given by MS.In case of emergency, Treating Consultant + On-duty EMO and counter signed by MS.

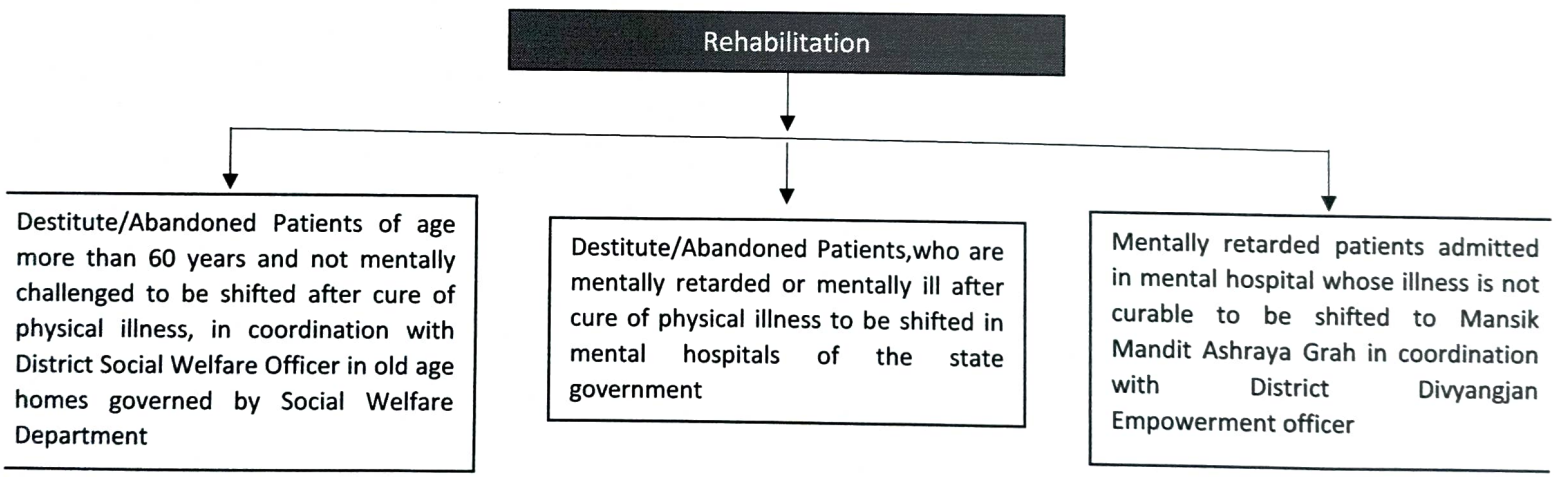
Admission and Treatment Flow Chart

	Formalities to be done	Responsibilities
Admission	MLC, Complete detail of brought by, mode of transport, referral hospital detail if any. Police Information Free Admission, and Starting of free Treatment	On duty CMO
	Unknown to be Assigned a Destitute Number from Destitute Register	MSSO
	Receiving of Police Information with D.D. No. and I.O. Name	SHO Saifai ASO to Liaison with Police
	Safety and Security in Wards	To be ensured by on-duty Nursing Officer/SNO/ANS in coordination with Security Team ASO to monitor and ensure to maintain a logbook for all the unattended patients admitted in that ward
	All belongings to be sealed if (he/she) is not able to carry	On duty Nursing Officer and handover to in-charge (Triage) Monitored by DNS/NS
	Consent for Emergency surgery/procedure	Concerned faculty/EMO/MS
After Admission	Treatment of the Patient	Concerned Consultant and Department
	General Care in the Ward / ICU	ANS to ensure General Care (To be monitored by DNS/NS)
In case of death	Shift body to Mortuary Police information to be send	Treating Consultant and Ward in-charge
Rehabilitation	After Treatment is Completed information to be sent to CMS office/ M.S. Office / Nodal / MSSO	Concerned Consultant
	Nodal Officer will Coordinate for Proper Rehabilitation as per G.O. No. **I/722081/2024/71-2099/11/2024**	Nodal Officer MSSO CMS/MS Office

As per letter Number-1/722081/2024 /71-2099/11/2024, Dated 21-08-2024 Chikitsa Siksha Anubhag-2-Chikitsa Siksha Vibhag Government of Uttar Pradesh,in Institutes under control of medical education Department of Uttar Pradesh following SOP is to be followed for the treatment and rehabilitation of destitute/abandoned/ mentally ill patients.

- Nodal officer to be nominated to ensure free treatment of destitute/abandoned/ mentally ill patients.
- Destitute/Abandoned Patient who are not mentally challenged to be admitted in concerned ward. If they are not able to do their routine activity attendant to be provided.
- Five beds (male + 2 female) to be marked for destitute/abandoned/ mentally ill patients and if needed further beds may be increased.
- Destitute/Abandoned Patient of age more than 60 Years and not mentally challenged to be shifted after cure of physical illness,in coordination with District Social Welfare Officer in old age homes governed by Social Welfare Department.
- Destitute/abandoned patients who are mentally retarded or mentally ill after cure of physical illness to be shifted in mental hospitals of state government.
- Mentally retarded patients admitted in mental hospital whose illness is not curable to be shifted Mansik Mandit Ashraya Grah in coordination with District Divyangjan Empowerment officer
- Rehabilitation is done only for admitted destitute/homeless patients who are fit for discharge.

Rehabilitation of destitute patients will be carried out by Nodal Officer and Medical Social Service Officer nominated for destitute patients under supervision of CMS/MS only once the patient is admitted and is fit for discharge.



Upon admission of an unknown or destitute patient all necessary documentation must be completed.

The Treating faculty sends a referral call to CMS/MS/Nodal Officer in writing, including details of the patients physical and medical condition, circumstances of admission and preliminary medical findings in provided format.

A. DESTITUE PATIENTS WITH MENTAL ILLNESS

A1. Diagnostic Threshold:

The Patient must meet the statutory definition of Mental illness under Sec 2(s) MHCA 2017: a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

- Suspected diagnoses: Schizophrenia, acute psychosis, bipolar disorder, severe depression with psychotic features, dementia with behavioral disturbance, substance-induced psychotic disorder.
- If only intellectual disability is present without co-morbid mental illness –proceed to - B.
- If capacity is present and patient wishes independent admission – Sec. 86 pathway.
- If capacity is absent or patient require very high support in decision making – Sec. 89 pathway.

A2. Nominated Representative (NR) – Hierarchy per Sec. 14 MHCA

Before Sec. 89 admission, an NR must be established. For destitute patients, follow this hierarchy in order.

Priority	NR Type	Action Required	Sec. Reference
1st	Advance Directive	Check if patient has registered AD naming an NR. Rare in destitute patients but must be checked	Sec. 14(4)(a)
2nd	Relative	Any traceable relative willing to act. Document all family tracing efforts. FIR under Sec. 100 (7) mandatory	Sec. 14(4)(b)
3rd	Care-giver	Any person actively providing care (NGO worker, shelter staff) who agrees to formally serve as NR	Sec. 14(4)(c)
4th	MHRB-appointed person	Apply to MHRB for suitable person appointment. Time-consuming – not for acute emergencies	Sec. 14(4)(d)
5th(Default)	Director, Dept. Social Welfare	Board shall appoint Director, Dept. Social Welfare (or designee) if no one else is available. This is the ULTIMATE DEFAULT for all destitute/wandering HPMI.	Sec. 14(4)(e)
TEMP	Temporary NR from NGO	Representative of a Societies Registration Act 1860 organisation working for PMI may be engaged temporarily by MHP to act as NR pending board appointment. Their written application to MO Psychiatrist is sufficient – MOST PRATICAL emergency option.	Sec 14(4) Proviso + Sec 14(5)

A3. Pathway A3a: Independent Admission – Sec. 86 MHCA

Use when patient has mental illness of requisite severity, **AND**has the capacity to consent and voluntarily requests admission

Patient makes written request for admission

MO/MHP must be satisfied: (a) severity warrants admission; (b) patient likely to benefit; (c) request is voluntary, without duress; (d) patient has the capacity to decide independently or with minimal support {Sec. 86(2)}

No NR required – patient's own consent is sufficient {Sec. 86(6)}

No MHRB intimation required for initial 30 days.

Document consent in case file. Patient may discharge themselves at any time unless Sec. 88(3) retention applies.

Sec. 88(3): If patient requests discharge but MHP believes they meet Sec. 89 criteria, they may be retained for up to 24 hours for assessment. Must convert to Sec. 89 or discharge within 24 hours.

A3b. Supported Admission (up to 30 days) – Sec. 89 MHCA

Use when: patient has mental illness of requisite severity AND lacks capacity (requires very high/approaching 100% support in decision making) OR does not voluntarily consent.

1. Establish NR per hierarchy above {Sec (14)}/ Written application from NR is required
2. Two independent examinations – both on the same day OR within the proceeding seven days
   (a) Examiner 1 Psychiatrist
   (b) Examiner 2 Mental Health Professional OR Medical Practitioner
3. Both Independently certify – all three of the following {Sec 89(1)}
   (a) Severity – patient has MI such that they have recently threatened/attempted to cause bodily harm to self OR behaved violently OR shown inability to care for self to a degree placing them at risk.
   (b) Least restrictive: admission to MHE is the least restrictive care option considering AD if any
   (c) In-capacity: patient is unable to make decision independently and needs very high support from NR
4. Admission duration up to 30 days {Sec 89(2)}
5. NR consent for treatment: NR may temporarily consent to treatment plan {Sec 89(7)}. Review capacity every seven days Sec 89(8)
6. MHRB report: mandatory
   a) Women OR minors: report to MHRB within three days Sec. 89(9)(a)
   b) Adult males: report to MHRB within seven days Sec. 89(9)(b)
7. If more than 30 days needed: proceed to Sec 90 pathways (To psychiatrists, MHRB review within 21 days.)

A4: Supported Admission beyond 30 Days – Sec 90 MHCA

- Triggered when patient admitted under Sec. 89 requires admission beyond 30 days, OR requires readmission within 7 days of Sec. 89 discharge
- Two psychiatrists independently examine. NR application required. Report to MHRB within 7 days.
- MHRB must review and either permit or deny within 21 days (Sec. 90(4)).
- Duration: up to 90 days initially; then 120 days; then 180 days at a time.
- CRITICAL: A destitute patient cannot be retained in MHE merely because they are homeless after clinical recovery - Sec. 19(1)(b) MHCA. Government is obligated to provide community alternatives.

A5. Open vs. Closed Ward - Clinical Decision

MHCA 2017 mandates the least restrictive environment principle. There is no automatic requirement to place HPMI in a closed ward.

- Open psychiatric ward is permissible and often preferable if the patient is not acutely dangerous.
- Closed/supervised ward indicated if: acute agitation, aggression, high risk of absconding, unknown forensic history.
- MHCA Sec. 95(d): Chaining in any manner or form is absolutely prohibited.
- Sec. 97: Seclusion is prohibited by default. Physical restraints only as last resort in emergency- document justification, duration, review time, and submit monthly report to MHRB.
- STRICTLY PROHIBITED: Placing PMI together with prisoners or persons under criminal detention.

A6. Rights of the Patient (Non-Negotiable)

Section	Right
Sec. 18(5)(b)(c)	**Treatment while living in community preferable; institutionalization is the last option, if so, for as brief time as possible**
Sec. 18(7)	Free treatment at all Govt. MHEs - no charges whatsoever for destitute/homeless PMI
Sec. 19(1)(b)	Cannot be retained in MHE merely due to homelessness or absence of family after recovery
Sec. 20(1)	Right to dignity - no cruel, inhuman or degrading treatment in any MHE
Sec. 20(2)(k)	Explicitly protected from all forms of physical, verbal, emotional and sexual abuse
Sec. 21(1)	Emergency services for MI must equal standard of care for physical illness
Sec. 27	MO/MHP in-charge has a duty to inform patient of entitlement to free legal services and provide

Sec. 19(1)(b) MHCA 2017:

A person shall NOT continue to remain in a MHE merely because he does not have a family, is not accepted by his family, is homeless, or due to absence of community-based facilities.

A7. Discharge Planning

- No destitute patient can be discharged onto the street - the 'No Street' Rule.
- If family traced: police facilitate reunion. Document handover formally.

B: Destitute Patient with Intellectual Disability

NO Co-morbid Mental Illness | Governing Law: RPWD Act 2016 + National Trust Act 1999

CRITICAL LEGAL NOTE:
Intellectual Disability (Mental Retardation) is EXPLICITLY EXCLUDED from the definition of Mental Illness under Sec. 2(s) MHCA 2017. Admitting a person with ID alone under MHCA 2017 would be legally incorrect. The correct pathway is RPWD Act 2016. If co-morbid mental illness is present, activate SOP-A for the mental illness component in addition. [Source: MHCA 2017, Sec. 2(s); RPWD Act 2016, Schedule]

B: Destitute Patient with Intellectual/any other Disability (No Mental Illness)

B1. Establishing the Diagnosis

- Intellectual Disability is characterized by: significant limitations in intellectual functioning (IQ <70) AND adaptive behavior, originating before age 18 (DSM-5 / ICD-11).
- Clinical assessment by Psychiatrist + Clinical Psychologist confirms ID and rules out co-morbid mental illness warranting an admission.
- Document clearly in case notes: 'No features of mental illness as defined by Sec. 2(s) MHCA 2017 are present. Patient has Intellectual Disability governed by RPWD Act 2016.
- If acute behavioral distruption: assess and treat as a medical emergency. If features of co-morbid psychosis emerge, activate SOP-A simultaneously.

B2. Immediate Protective Action - RPWD Act Sec. 7

Sec. 7(1) RPWD Act 2016:
The appropriate Government and the local authorities shall take measures to protect persons with disabilities from all forms of abuse, violence, and exploitation. This section creates a mandatory duty - the word 'shall' is operative.

- Hospital administration must notify the District Magistrate / Collector in writing under Sec. 7 RPWD Act within 24 hours.
- Simultaneously notify the District Disability Rehabilitation Centre (DDRC) - nodal district-level authority for disability welfare.
- Copy to the Chief Medical Officer (CMO) of the district - for government record and welfare coordination.
- Retain patient in hospital under general duty of care while process is initiated - document daily in case notes: 'Patient retained pending welfare placement under RPWD Act Sec. 7 and 93. Referrals sent to DM and DDRC on [date].'

B3. Disability Certification - RPWD Act Sec. 57-58

- Initiate Disability Certificate process via the hospital's Medical Board (Psychiatrist + Clinical Psychologist + relevant specialist).

- Certificate specifies: type of disability (Intellectual Disability), percentage of disability, permanent or temporary.
- Must be issued free of cost (Sec. 58 RPWD Act).
- Disability Certificate is the gateway to all legal protections, welfare benefits, and guardianship
- proceedings under RPWD Act 2016.

B4. Guardianship & Legal Representation

Unlike MHCA where an NR can be informally arranged, guardianship under RPWD Act requires a formal process:

B4a. If no family is available (Destitute):

- Apply to the District Court for appointment of a Legal Guardian under Sec. 14 RPWD Act 2016
- Sec. 15 RPWD Act: Guardian has power to take decisions on personal care, treatment, financial affairs, and placement.
- Sec. 16 RPWD Act: Guardianship subject to Court review. Guardian is accountable and cannot act against the person's best interest.
- This is time-consuming - maintain patient in hospital during this period with documented daily welfare notes.

B4b. If family is available but needs formal guardianship:

- National Trust Act 1999, Sec. 14: Local Level Committee (LLC) can appoint a guardian for persons with autism, cerebral palsy, mental retardation, or multiple disabilities.
- Faster process than District Court - contact local LLC for immediate registration and appointment.
- LLC-appointed guardianship preferred when family is available and cooperative.

B5. Placement in Care Institution - RPWD Act Sec. 93 & Sec. 24

- Sec. 93 RPWD Act: State Government is mandated to establish and maintain homes, shelters, and rehabilitation centres for destitute persons with disabilities.
- Sec. 24 RPWD Act: Every person with benchmark disability (40%+) who is destitute has a right to free residential facilities from State Government.
- Refer to: DDRC (primary), State-run homes for persons with ID under Social Welfare Department, NGO-run homes registered under National Trust Act.
- If State Commissioner has not acted within 7 days: escalate under Sec. 80-81 RPWD Act to State Commissioner for Persons with Disabilities.

B6. Discharge & Handover

- No destitute person with ID can be discharged onto the street.
- Discharge only to: family/guardian (if traced); DDRC-arranged placement; NGO-run care home; State welfare home
- Provide complete medical summary, disability certificate copy, and follow-up instructions.
- Formal written handover with receiving institution's acknowledgement signature.

4.Nodal officer and Medical Social Service Officer-

a. To note the referral call and ask about photocopy of necessary documents for rehabilitation, including;
   - Formal referral call
   - Front admission sheet
   - Medical condition report
   - Psychiatric evaluation report
   - Patient consent letter
   - Investigation officer clearance
   - Supporting documents from treating department

b. Conduct a comprehensive patient assessment, considering psychological, social, environmental, and biological factors.

c. Coordinate with concern faculty and doctor on duty to understand the patient's medical history, medication, and any relevant condition affecting rehabilitation.

d. Ensure all documents are complete; MSSO must verify that all required documents are in place before proceeding with the transfer.

e. Coordinate with NGOs; Nodal officer and MSSO must liaise with rehabilitation shelter homes/NGOs to discuss the case, medical, social and psychological condition of the patient, and identify a suitable placement.

f. Coordinate with hospital staff; MSSO must monitor the patient's medical condition in coordination with treating doctors to determine if they are fit for transfer.

g. MSSO will maintain the record/register of admitted destitute patients and assign destitute no. for each admitted destitute patient.

h. Discharge process; MSSO to coordinate with treating Doctorand shelter home /NGO person for smooth rehabilitation of patient.

5. I/O CLEARANCE;

a. The assigned investigation officer must provide written clearance before any transfer.

b. The IO is responsible for attempting to locate the patient's home and family. If the patient's home and family are not traceable, the IO must issue a written statement confirming efforts were made, but no relatives were found.

c. The clearance must also confirm that there are no pending criminal cases against the patient and must include the IO's name, signature, police station detail, belt number, DD Number, designation and contact information.

6. **Comprehensives Medical Assessment;**

a. Viral marker test, in-case of female patients of child bearing age Urinary pregnancy test
b. Detailed examination by Hospital Medical Board including Psychiatrist, Clinical Psychologist and relevant specialty.
c. Psychiatric evaluation; a detailed psychiatric evaluation must be conducted by a psychiatrist to assess the patient's mental health and determine if any psychological conditions require specialized care.

10.

7. Patient consent letter;

a. A written consent letter from the patient is required before transfer to a rehabilitation shelter home/NGO.
b. The patient must acknowledge that they have no place of residence and no one to take care for them and they voluntarily request to be transferred to an NGO or shelter home for accommodation and food arrangements.
c. Minors and psychiatric patients are exempted from providing consent.

8. Specific Protocol for special category of patients

a. **Unconscious patients:** these patients shall not be transferred to a rehabilitation shelter home until they are declared medically stable and regain their consciousness. The care of these patients remains the responsibility of the hospital.
b. **Foreign Nationals:**For foreign nationals patients, the treating department must contact the investigation officer and the concerned Officer In charge Handling foreign national cases.
c. **Adult psychiatric patients:** Treating department to contact the concerned IO of the case and IO collects the reports from doctor and presents the case in court.
d. **Minor /Children:** These patients can only be transferred after obtaining a formal order from the Child Welfare Committee. The must acquire necessary documents from concern department and present the case to CWC. once the order is received the IO will transfer the child to a suitable home as per CWC guidelines.
e. **Psychiatric Children:**These patients can only be transferred after obtaining a formal order from the CWC. Nodal officer and IO must facilitate the process to comply with child welfare laws and ensure the best interest of the child.

9. Protocol forfinal rites of Destitute Patients;

In case of a destitute/ unknown patient's death or is brought dead in hospital/ found dead in hospital premises, after medicolegal formalities the dead body is shifted to mortuary for autopsy and police information to be send. Further formalities to be completed by police.

This SOP aims to streamline the process leading to faster and more efficient outcomes and to standardize the process for dealing with unknown and destitute patients, ensuring that no patient is discharged without proper follow up care and rehabilitation measures in place.

By adhering to the guidelines in SOP all stakeholders involved – medical professionals, MSSOs, law enforcement authorities and NGOs can work collectively to ensure that no unknown/destitute patient is left without care, support or the opportunity for a better future. The UPUMS is committed to ensuring that these patients are not abandoned after receiving medical treatment but are instead rehabilitated into a safe and supportive environment that enables them to lead a dignified life.

With compassion,diligence and commitment UPUMS strives to uphold the fundamental right to healthcare, dignity, and rehabilitation for every patient, regardless of their social or economic background.

Mr. Manoj Kumar Maurya
MSSO Grade-I

Mrs. Geeta Kumari
GITA KUMARI
Nursing Superintendent

24/04/2026
Dr. Vishw Deepak
Chief Medical Officer
(Emergency)

Dr. Himanshu Prince Yadav
Asst. Prof. (Dept. of Anesthesia)

24/04/2026
Dr. Vedant Kulshreshtha
Asso. Prof. (Forensic Medicine)

Dr. Ram Lakhan Singh Verma
Asso. Prof. (General Surgery)

Dr. Prashant Choudhary
Ass. Prof. (Dept of Psychiatry)

24/04/26
Dr. Ajay Kumar Rajput
Asso. Prof. (Dept. of Orthopedics)