APPLICATION FOR REGISTRATION

FOR HEALTHCARE ESTABLISHMENTS (HCE's)

Having Outdoor Facilities

NOTE

- Healthcare Establishments are required to complete this form as per provisions of the Sindh Healthcare Commission Act 2013.
- **Required Documents: (**Pertaining to the Healthcare Service Provider)
  - CNIC
  - Copy of qualifications
  - Copy of valid registration with the relevant Council (PM&DC/PNC/NCH/NCT), if applicable.
- Duly filled Annexure A, B, C &D
- **Incomplete forms will not be entertained.**
- **Provision of incorrect information/documents will result in rejection of the Application**.
- **Return the completed form to:**

Director Licensing &Accreditation Sindh Healthcare Commission 2nd Floor, Block-C, FTC building Shahrah-e-Faisal, Karachi.

- Questions regarding completion of this application may be directed to: Ph.021-38656000, Toll Free: 080007422
- For further information, please visit our website: **www.shcc.org.pk or ra@shcc.org.pk**

I. GENERAL INFORMATION

A. HEALTHCARE SERVICE PROVIDER

Name:		Designation:	
Status:	☐ Owner	☐ Manager	☐ In-charge
Qualification:		CNIC Number:	
Valid Registration No. PMDC/PNC/NCH/ NCT:			
Mailing Address:			
Town/Taluka:		City:	District:
Landline:		Fax:	Email:
Mobile:			

B. HEALTHCARE ESTABLISHMENT

Name:		Date of Establishment at present location: (_____ /_____ /_____)	
Mailing Address:			
Town/Taluka:		City:	District:
Landline:		Fax:	Email:
Mobile:			
Previous Name & Address (If any):			

C. TYPE OF OWNERSHIP: (Please check the appropriate box)		
Government	**Others**	
☐ District Government	☐ Sole Proprietary	☐ Voluntary Non-Profit
☐ Provincial Government[1]	☐ Partnership	☐ Association
☐ Federal Government	☐ Corporation	☐ Limited Liability Company (Private)
☐ Autonomous Institution	☐ Trust	☐ Limited Liability Company (Public)

D. TYPE OF HEALTHCARE ESTABLISHMENT (Please check the relevant box)

☐ Single Specialty (please specify):_____

☐ Multiple Specialty

☐ Others

GP Clinic/Homeopath/Hakim/Lab/Collection Center/Radiological & Diagnostic Imaging Center /MaternityorNursingHome/DentalClinic/CosmeticSurgery/LaserClinic/Physiotherapist/Acupuncturist/_____ _____

Any other: _____

E. DEPARTMENTS / SERVICES PROVIDED BY THE HEALTHCARE ESTABLISHMENT

S.No.	Healthcare Services

_____

F. OTHER BRANCHES				
S.No.	**Name**	**Address**	**Contact No.**	**Services provided**

G. SUMMARY OF STAFFING

Indicate number of full time **(FT)** and part time **(PT)** employees. (Attach additional pages if necessary).

S. No.	Category	FT	PT
01	Board Membership (if applicable)		
02	Management		
03	Consultants		
04	Medical Officers		
05	Nursing		
06	Support Services		
07	LHV		
08	Technicians		
09	Midwives		
10	Physiotherapy Assistants		
11	Receptionist		
12	Pharmacy		
13	Physiotherapist		
14	Occupational therapist		
15	Speech therapist		
16	Volunteers		
17	Others		
TOTAL			

II. MANAGEMENT

A. HCE MANAGER/ INCHARGE

Name:

Title:

☐ Male ☐ Female	Date of Joining: _____ /_____ /_____	Status: ☐ Interim ☐ Acting ☐ Permanent

Email: Phone Landline: Mobile:

Does the HCE Manager/Incharge run more than one facility? ☐ Yes ☐ No

If yes, Name of facility, address and city:

Professional and Educational Qualifications of the HCE Manager/Incharge:

B. PHARMACY INCHARGE (If applicable)		
Name:	Date of Joining:_____/_____/_____	
Title:	Male/Female	
Email:	Landline:	Mobile:
Professional and Educational Qualifications:		

C. LABORATORY INCHARGE (If applicable)		
Name:	Date of Joining:____/_____/___	
Title:	Male/Female	
Email:	Landline:	Mobile:
Professional and Educational Qualifications		

IV. OWNERSHIP

A. APPLICANT (OWNER)		
Identify person(s) or business entity having the authority to direct the management or policies of the facility.		
Name:		
Permanent Address:		
Mailing Address (if different from above):		
Building No.	Town:	City
Contact No.	Fax:	Email:
Name of Focal Person for SHCC:		
Designation of Focal Person:		
Landline:	Mobile:	Email:
Holding (what the owner owns)	☐ Operations ☐ Building	☐ Land

B. CHANGE OF OWNERSHIP
Previous owner's name:
Address:

C. PARENT COMPANY INFORMATION		
Is the applicant a subsidiary company, either wholly or partially owned by another organization or company? ☐ YES ☐ NO If yes, Provide the following information.		
Name of the Parent Company:		
Doing business as:		
Type of Ownership:		
Mailing Address:		
Email:	Telephone:	Contact Person:

DECLARATION

I, the undersigned, do hereby solemnly affirm and declare that the HCE

_____

Provides no indoor services and the information provided above is true and correct to the best of my knowledge and belief and that nothing has been concealed there from. I understand that if any false or incorrect information is provided to the Commission, it may result in rejection of my application for license and I may also be found liable to pay fine to the Commission. I further undertake to inform the Commission in writing, within fifteen days of any addition/alteration made in the services/premises, at any time in future.

Signature	**Name of Applicant:**
Date Signed:	**Designation:**

Appendix A: Information of Full Time Staff

Sr. No.	NAME	DESIGNATION	REGISTRATION (PMDC/PNC/NCH/NCT/SMF)		CONTACTINFORMATION	
			Number	Valid up to	Phone No.	Email

Appendix B: Information of Part Time Staff

Sr. No.	NAME	DESIGNATION	REGISTRATION (PMDC/PNC/NCH/NCT/SMF)		CONTACTINFORMATION	
			Number	Valid up to	Phone No.	Email

Appendix C: List of Electro-Medical Equipment

Sr. No	Name of Equipment	Make	Model	Functional (No.)	Non-Functional (No)

Appendix D: List of Machinery & Transport

Sr. No	Name of Machinery/Transport	Make	Model	Functional (No)	Non-Functional (No)

For Issuance of Registration Certificate

To,
Director Licensing & Accreditation
Sindh Health Care Commission

Subject: **ISSUANCE OF REGISTRATION CERTIFICATE**

It is respectfully submitted that:

1. I am owner/manager of _____
   teaching/non-teaching _____
   bedded HCE _____ (address). _____
2. I applied for registration of the said hospital on prescribed format on dated ____ ____ ____
   which was received by the Commission wide dairy No. _____ dated _____ _____ _____
   /dispatched by courier services with receipt No. _____ dated _____ _____ _____
   (copy enclosed).
   It is required that the Registration Certificate may please be issued in favour of _____
   without any further delay.

Thanks

Yours Sincerely

Owner/Manager of Health Care Establishment

Name _____

Address _____

_____

Dated: _____ _____ _____

FOR OFFICE USE ONLY

1- Any objection on registration _____

2- Recommended for registration Yes/No. _____

Forwarded to the Director Licensing & Accreditation for approval

Registration approved
Director Licensing & Accreditation
Sindh Health Care Commission