APPLICATION FOR REGISTRATION FOR HEALTHCARE ESTABLISHMENTS (HCE's)

Having Indoor 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 Appendix 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 FTC, Block-C building Shahrah-e-Faisal, Karachi.

- Questions regarding completion of this application may be directed to: Ph.021-38656000 or Toll free:0800 07422
- For further information, please visit our web site: **www.shcc.org.pk or ra@shcc.org.pk**

I.GENERAL INFORMATION

A. HEALTHCARE SERVICE PROVIDER

Name:			
Designation:			
Status	☐ Owner	☐ Manager	☐ In-charge
CNIC #:			
Qualification:			
Valid Registration No.PMDC/ PNC/ NCH/ NCTor any other:			
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	☐ 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)

☐ Teaching

☐ Non -Teaching

☐ Single Specialty (please specify):_____

☐ Multiple Specialty

☐ Others

GP Clinic/ Homeopath/ Hakim/ Lab/ Collection Center/ Radiological & or Diagnostic Imaging Center /Maternity or Nursing Home/ Dental Clinic/ Cosmetic Surgery/ Laser Clinic/ Physiotherapist/Acupuncturist/ _____

Any other: _____

E. EXTERNAL VALIDATION

List all applicable external certificates, licenses, accreditation and similar Awards/Certificates

☐ Agency_____Award:_____

☐ Agency_____Award:_____

☐ Agency_____Award_____

☐ Agency_____Award_____

☐ Agency_____Award_____

F. DEPARTMENTS /SERVICES PROVIDED BY THE HEALTHCARE ESTABLISHMENT

S.No.	Departments/Services	Indoor			OPD
		Total Beds	Male	Female	Y/N
01	General Medicine				
02	Pediatrics				
03	Cardiology				
04	Dermatology				
05	Psychiatry				
06	Endocrinology				
07	Gastroenterology				
08	Hepatology				
09	Neonatology				
10	Neurology				
11	Oncology				
12	Rheumatology				
13	Pulmonology				
14	CCU				
15	Homeopathy				
16	Tibb				
17	Nutrition				
18	*Others* (please specify)				
19	Emergency				

F. DEPARTMENTS /SERVICES PROVIDED BY THE HEALTHCARE ESTABLISHMENT

S.No.	Departments/ Services	Indoor			OPD
		Total Beds	Male	Female	Y/N
20	Blood Bank				
21	Laboratory				
22	Radiology & diagnostic Imaging				
23	Pharmacy Indoor				
24	Pharmacy Outdoor				
25	Physiotherapy				
26	Speech Therapy				
27	Social Welfare				
28	*Others* (please specify)				
29	General Surgery				
30	Orthopedics				
31	Trauma Management				
32	O.T.				
33	ENT				
34	Eye				
35	Gyne & Obs				
36	Pediatric Surgery				
37	Cardiac Surgery				
38	ICU				
39	Neurosurgery				
40	Facio-maxillary				
41	Urology				
42	Plastic Surgery				
43	Dentistry				
44	*Others* (please specify)				
Total					

G. OFF SITE LOCATIONS[1]	
☐ YES	☐ NO
Name of Offsite Location: Address: City: Services Provided:	Type of Establishment: Telephone Number: Number of Beds:

H. SUMMARY OF STAFF

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

	FT	PT
1. Board Membership (if applicable)		
2. Management		
3. Medical/Surgical Services		
a. Consultants		
b. Medical Officers		
c. House Officerss		
4. Nursing		
5. Post Graduate Students/ Residents		
6. Support Services		
7. Allied Health		
a. LHV		
b. Technicians		
c. Midwives		
d. Physiotherapy Assistants		
e. Health aide		
f. Receptionist		
8. Pharmacy		
9. Therapists		
a. Physiotherapist		
b. Occupational therapist		
c. Speech therapist		
10.Volunteers		
11.Others		
TOTAL		

II. BUILDING PLANS & MACHINERY

A. Building Plans

Do you have building Plans? ☐ Yes & complete ☐ Yes but incomplete ☐ No

Are building alterations and remodeling Proposed in the next 5 years? ☐ Yes ☐ No

Number of floors:	Residential Accommodation
Number of Generators:	Parking[3]:
Fire Exit:	☐ Yes ☐ No
Number of Chillers	

[1]Off site locations will include any type of collection centers, laboratories, branch sites etc.
[3]Please provide information in terms of sq. ft.

IEF CHIEF EXECUTIVE OFFICER (CEO)/CHIEF OPERATING OFFICER (COO)/INCHARGE

Name:

Title:

☐

Male ☐ Female Date of Joining: ____

Status:
☐ Interim ☐ Acting ☐ Permanent

Email: Phone Landline: Mobile:

Does the CEO/COO/Incharge run more than One Facility? ☐ Yes ☐ No

If yes,
Name of facility, address and City:

Professional and Educational Qualifications of the CEO/COO/IC

B. PERSON INCHARGE IN ABSENCE OF CEO / COO/ IC (SUBSTITUTE ADMINISTRATOR)

Name: Date of Joining: _____/_____/_____

Title: Male/Female:

Contact Details:	Telephone:	Fax:	Email:

Professional and Educational Qualifications:

C. MEDICAL DIRECTOR/ MEDICAL SUPERINTENDENT/ EQUIVALENT

Name:

☐ Male ☐ Female		Date of Joining / /

Title:

Status: ☐ Interim	☐ Acting	☐ Permanent	

Fax:	Landline:	Mobile:

E mail:

Is the Medical Director Incharge of more than one facility?	☐ Yes	☐ NO
If yes, Name of facility, Address and City:		
Professional and Educational Qualifications:		

D. NURSING SUPERINTENDENT/ EQUIVALENT

Name:	Date of Joining: ____ ____ ____	
Title:	Male/Female	
Email:	Landline:	Mobile:
Professional and Educational Qualifications:		

E. PHARMACY INCHARGE

Name:		Date of Joining: ____ / ____ / ____
Title:		Male/Female
Email:	Landline:	Mobile:
Professional and Educational Qualifications:		

F. LABORATORY INCHARGE

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 SHCC.					
Designation of Focal Person:					
Telephone Number:		Cell:			
Holding (what the owner owns)	☐ Operations	☐ Building	☐ Land		

B. CHANGE OF OWNERSHIP

Previous owner's Name:

Address:

Contact No: Email:

C. PARENT COMPANY INFORMATION		
Is the applicant as 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:		
City:	Telephone:	Contact Person:

DECLARATION

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

_____

Provides 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 departments/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