



SINDH HEALTHCARE COMMISSION
Quality Care for All

Sindh Health Care Commission



TRAINING APPLICATION & NOMINATION FORM

Name of Health Care Establishment (HCE): _____

SHCC Registration No. of HCE: _____

SHCC Provisional License No: _____ ☐ Not Available

Reason: ☐ PL Applied and Awaiting Verification Visit ☐ PL Applied and Verification Visit done
☐ PL Not Applied

Complete Address of HCE: _____

Mailing Address for Courier (if different from HCE address): _____

FACILITY CONTACT PERSON INFORMATION

Name of Contact Person: _____

Day Time Phone No. of Contact Person (Mon to Friday 9 am to 5 pm): _____

WhatsApp No. of Contact Person (If different from above): _____

RELEVANT STANDARDS ON WHICH TRAINING IS REQUIRED

☐ SSDS for Hospitals	☐ SSDS for Primary Healthcare /Medical Centre
☐ MSDS for GP Clinics	☐ MSDS for Homeopathy
☐ MSDS for Tibb-e-Unani	☐ MSDS for Dental Clinic
☐ MSDS for Dental Hospital	☐ MSDS for Clinical Diagnostic Laboratories
☐ MSDS for Laboratory Collection Point	☐ Other

NOMINEE/S ELIGIBILITY CRITERIA

Criteria for Training Participant by Facility Type

1) GP Clinic, Dental Clinic, Matab, Homeopathy Clinic, Maternity Home

- One nominee who is Practitioner/Owner is allowed

2) PHC Center/ Medical Center

- Two nominees are allowed; One nominee must be from a Medical Background and one nominee may be from the Management side.

3) Hospitals

For Hospitals, Senior Management team members (Hospital CEO/COO/Medical Director/Medical Superintendent/Deputy Medical Superintendent) who have decision making power and are well versed in both Clinical and Management side are recommended to attend. At least one representative/lead from all key sections of



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the SSDS for Hospitals is recommended to attend from following suggested departments:

- Senior Management, Finance, HR, Medical Records, Quality Assurance, Security and Safety Management
- Heads of Clinical Inpatient and Outpatient departments (Medicine, Surgery, Gynae etc) and Nursing
- Infection prevention and Control, House Keeping, CSSD and Waste Management
- Critical areas OT, ICU, CCU, CATH Lab, ER
- Auxiliary Services Pharmacy, Laboratory, Radiology, Food Services, Biomedical Engineering
 - Designated Junior team member who will be responsible for preparing HCE for SHCC Inspections may attend with senior leads

NOMINEE DETAILS

1) Full Name _____

Designation _____

Qualification _____

CNIC No. _____

2) Full Name _____

Designation _____

Qualification _____

CNIC No. _____

- Please attach a separate sheet with above info if nominees are more than two
- If there are number of HCEs under same management, please attach list of ALL HCEs with SHCC registration number or Un-registered in status column.

FEE SUBMISSION DETAILS

Fee as per fee structure can be paid via

- NBP Bank Challan available at SHCC office
OR
- Online transfer:
IBAN No.: PK46SIND0003384447401000
Sindh Bank Account No: 0338-444740-1000
Account Title: Sindh Health Care Commission



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Payment Details:

NBP Bank Challan Serial No. _____ Date of Deposit. _____

Branch Name & Code: _____

Amount Deposited: _____

Online Payment:

From Account Number: _____ Payee Name: _____

Amount Deposited: _____

Online payment receipt printout to be attached.

Check List of Documents to be attached& DOCUMENT

No	Documents Description	Attached ✓/(NA)
1	Original and Copy of Fee Deposit Slip	
2	Copy of SHCC Registration Certificate	
3	Copy of Provisional License or Submission Receipt	
4	National Identity Card Copies of the Nominees	
5	List of Nominees (If applicable)	
6	List of all HCEs under same Management (If applicable)	
7	Other	

Declaration and Undertaking

I _____ S/o, D/o _____ do hereby solemnly declare and undertake that:

1. The information provided in this application form, as well as the accompanying documents, is true, accurate, and complete to the best of my knowledge and belief.
2. I understand and acknowledge that any misrepresentation, concealment of facts, or submission of false information may result in the rejection of this application and/or cancellation of registration/license at any stage without notice.
3. I undertake to abide by all applicable laws, rules, regulations, and guidelines as prescribed by the Commission, and shall remain compliant with any future amendments therein.
4. I confirm that all required documents, as per the checklist have been duly attached for verification and processing.

Name: _____

Designation: _____

Date: _____

FOR OFFICE USE

DCGT VERIFICATION AND APPROVAL

Training Session Category

- ☐ Fresh Training
- ☐ Previously Absent
- ☐ Trained Person Changed
- ☐ Other

Verification of Nominee

- ☐ Verified that Nominee is same as FP in DLA DATABASE
- ☐ Nominee name is not in DLA Database
- ☐ Nominee Verification Form from DLA Completed and Attached

APPROVAL:

Approved by Director Clinical Governance & Training (DCGT)

Approved ☐ Not Approved ☐ Date and Signature: _____

SHCC Training Fee Structure Approved 27 April 2026 17 th EC Meeting for immediate implementation		
Standards and Category	Training Duration	Fee
SSDS for Hospitals Hospitals Cat I A to I F (>50 beds)	One full day In - Person	- PKR 30000/up to 10 participants - 3000/each additional participant
MSDS For Dental Services Dental Hospitals	One full Day In - Person	
SSDS for Hospitals Hospitals Cat II A and B (< 50 beds) including Medical Centers and Maternity Hospitals	One full day In - Person	- PKR 25000/up to 10 participants - 2500/each additional participant
MSDS for Clinical Diagnostic Labs Category IV	One full Day In- Person	- In-person 25000/- up to 10 participants - 2500/each additional participant
MSDS for Lab Collection Points Category IV	Half Day	- PKR 3000/ participant for in-person and PKR 1500/ participant online
SSDS for PHC Category III	Half Day	
MSDS for Clinics Category III	Half Day	
MSDS for Dental Clinics Category III	Half Day	
MSDS for Homeopathic Establishment Category III	Half Day	
MSDS for Matabs Category III	Half Day	
• 1 manual free/HCE; Cost of each additional Manual- PKR1000/- • To be paid via NBP voucher Section 4 (i) FEE > Write “TRAINING FEE” • Attach Paid Voucher with Completed Training Application Form and all requisite documents and submit to Directorate of Clinical Governance & Trainings		