

**APPLICATION FORM FOR THE ESTABLISHMENT AND
OPERATION OF A PRIVATE HEALTH INSTITUTION**

- I. Use black ink and write in capital letters.
- II. Where the space provided is found to be insufficient the applicant may continue on a separate sheet which shall be appropriately numbered and attached to the application form.
- III. If not applicable, write “**not applicable**”. Do not leave blank spaces.

1. GENERAL INFORMATION

1.1 Type of private health institution the applicant wishes to operate or is presently operating (Please tick as appropriate)

- (a) Clinical Laboratory
- (b) Health Care Unit
- (c) Hospital
- (d) Nursing Home
- (e) Other (please specify)

1.2 Which of the following are you applying for?(Please tick accordingly):License for:

- (i) The operation of an existing health institution
- (ii) The extension and operation of an existing health institution
- (iii) The establishment and operation of a new health institution
- (iv) Change of ownership of an existing health institution
- (v) other(please specify)

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1.3 Name and address of existing health institution(in case of new health institution, give the proposed name and address)

Name	Address	Tel No./Fax No.

1.4 In the case of an existing health institution, indicate the year when institution first became operational?

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1.5 In case of the establishment of a new health institution, indicate the proposed date when services are to become operational.

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1.6 Is this your first application for a licence? (tick as appropriate)

(i) Yes

(ii) No

If No: give date of last application and reference number

Date:

Ref No:

1.7 Are you applying for yourself or on behalf of a company/association? Give the name and address of the applicant company/association, including the company's/association's registration number, otherwise specify the full name and address of the applicant(s)

Name	Address	Registration No	Tel No. Fax No.

1.8 In case of an existing institution, give the name, residential address of the present Head of the institution and of the person in charge (if different from the Head).

	Name	Address	Tel No./Fax No.
Head			
Person in Charge			

1.9 In the case of establishment of a new health institution, give the name, address and current occupation of the proposed Head of the institution.

Name	Address	Current occupation

1.10 Qualification and experience of the Head (attach curriculum vitae of the Head, giving details with supporting documents)

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2. **PREMISES**

2.1 Two set of plans of the existing or the proposed buildings shall be attached to the application form.

2.2 Indicate the following:

- (i) Total floor space of premises (square meters).....
- (ii) Total area of land
- (iii) Indicate if freehold or leasehold

- (iv) Indicate, if any, the amount of rent being paid in respect of business premises (Rs)
- (v) Name and address of proprietor of premises(if different from that of the applicant)

Name	Address	Tel No./Fax No.

3. **FINANCIAL FEASIBILITY REPORT**

A Financial Feasibility Report as certified by an approved company of Chartered Accountants should be submitted together with the present application form in the following cases:-

- (i) establishment of a new health institution; and
 - (ii) major extension of an existing health institution.
- (Section 3 does **not** apply to health care units)

4. **SERVICES PROVIDED**

4.1 For a hospital, indicate whether the following services are available in the existing health institution or if they are to be provided in a new health institution? (tick accordingly)

- (a) Emergency service
- (b) Inpatient service
- (c) Outpatient service

4.2 In the case of an existing health institution, briefly describe the type of services (including support services and ancillary facilities)provided in the health institution

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4.3 In the case of a new health institution or the extension of an existing health institution, briefly describe the proposed services (including support services and ancillary facilities) to be provided when services become operational.

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4.4 Give the following numbers if application is for a hospital or nursing home
 (Note: *actual numbers are to be given for an existing institution, **proposed numbers are to be given in case of the establishment of a new institution as expected on the date when services become operational or in case of major extension of an existing hospital)

(i) **Total number of beds/cots**

	Actual Number	Proposed Number
Beds		
Cots		

(ii) **Number of bedrooms**

	Actual Number	Proposed Number
Single		
Double		
Multiple		

(specify number of beds in each type of multiple bedroom)

(iii) Number of operating-theatres(applicable to hospital only)

Actual Number

Proposed Number

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5. **SANITARY FACILITIES**

(i) **Number of toilets**

Number of bathrooms

Male

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Female

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(ii) Adequacy of running water:

Storage tanks :

Water sampling :

(iii) Mode of pathological waste disposal:

Incinerator or other open heat furnace:

If others(please specify):

(iv) Mode of solid waste disposal(refuse):

(v) Mode of kitchen waste disposal:

(vi) Mode of sewerage disposal:

(vii) Laundry/Linen Room:

Type available:

6. **STAFFING OF HEALTH INSTITUTION**

- (i) Give an account of the number of persons which the existing health institution intends to employ when services become operational.

	Actual Number	Proposed Number
Specialist		
Pharmacist		
Dental Surgeon		
Nurse		
Nurse-Midwife		
Assistant Nurse		
Auxiliary Nurse		
Radiographer		
Laboratory Technician		
Administrative Staff		
Cooks		
Servants		
Others (specify)		

- (ii) Give the total number of staff actually employed by an existing health institution or the proposed number for a new health institution.
 Total number of staff
- (iii) Expatriate staff: indicate the numbers employed, nationality, qualifications and period of employment in the case of an existing health institution.

Qualification	Number	Nationality	Period of Employment

- (iv) Give full names, qualifications and addresses (office address) of the Specialists who are on the panel of Specialists in the case of an existing hospital.

Name	Qualifications	Address

7. **EQUIPMENT**

- X-Ray :
- Laboratories :
- Other(specify) :
- Ambulance :

DECLARATION

I/We declare that the particulars given in this application are to the best of my/our knowledge and belief, true and correct and that any estimates in this application have been made in good faith and with all due care.

I/We hereby abide to comply with the Private Health Institutions Act and any condition attached to the licence.

Signed:

Designation:

Signed:

Designation :

Dated on this **day of****20**