GOVERNMENT OF PAKISTAN
ISLAMABAD HEALTHCARE REGULATORY AUTHORITY (IHRA)

PRCS-DMLC Building (2nd Floor) Sufi Tabassum Road,
H-8/2, Islamabad.
Ph: 051-9250 383

Form No: REG/IHRA/2021/_____

APPLICATION FOR REGISTRATION HAVING "INDOOR FACILITY"

Healthcare Establishments are required to complete this form as per requirements of the provision under Section 21 of the Islamabad Healthcare Regulations Act, 2018.

A. HEALTHCARE ESTABLISHMENT	
Name of the Healthcare Establishment:	Date of establishment at present location: D D - M M - Y Y Y Y
Previous Name (if any):	
Mailing Address:	Longitude: _____ Latitude:
Landline:	Mobile:
Email address:	

B. TYPE OF HEALTHCARE ESTABLISHMENT (please tick the relevant box)

- ☐ **Teaching**
- ☐ **Non-Teaching**
- ☐ **Single Speciality (please Specify): _____**
- ☐ **Multiple Speciality: _____**
- ☐ **Others: _____**

C. BED STRENGTH

- ☐ **Number of Beds: _____**

D. TYPE OF OWNERSHIP	
☐ **Sole Proprietorship**	☐ **Voluntary Non-Profit**
☐ **Partnership**	☐ **Association**
☐ **Corporation**	☐ **Limited Liability Company (Pvt)**
☐ **Trust**	☐ **Limited Liability Company (Public)**

	☐ **Others_____**

E. APPLICANT DETAILS

Name:	
Designation: Status: Owner ☐ Manager ☐ In-charge ☐	
Qualification:	
PMC/PNC/NCH/NCT Registration No:	
CNIC No: ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	
Mailing Address:	
Landline:	Mobile
Email:	

Required Documents:

- Copy of CNIC of applicant
- Declaration attached to this application (Page # 3) should be signed and stamped.
- Affidavit by the Healthcare Service Provider on Stamp Paper of Rs 50/- issued in his/her name if the Healthcare Service Provider is not the owner.
- Appendixes A, B and C to be completed
- Fee Deposited Receipt (Refer to Appendix-D)

Instructions:

- Fee to be deposited in Islamabad Healthcare Regulatory Authority (IHRA) Current Account No. **1150420000481** in Askari Bank Limited, Kamran Center Branch, Islamabad
- Each page shall be signed and stamped by the applicant
- Incomplete Form will not be entertained
- Provision of incorrect information/documents will result in rejection of application.
- Return the completed Form to:

Director Registration, PRCS-DMLC Building (2nd Floor)
Sufi Tabassum Road, H-8/2, Islamabad.

(For queries regarding completion of the application, please contact IHRA **Ph: 051-9250383** 9:00 am to 5:00 pm working days only)

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DECLARATION BY HEALTHCARE ESTABLISHMENT

I, undersigned, do hereby solemnly affirm and declare that the HCE (Name of HCE)

_____

provides services as above, and that the information provided above is true and correct to the best of my knowledge and belief and that nothing has been concealed therefrom. I also state that if any false or incorrect information is provided to the Authority, it may result in the rejection of my application for registration and I may also be found liable to pay fine to the Authority.

Signature:	Name of Applicant:
Date Signed:	Designation:

Appendix A: Information of Full Time Doctors/Staff

Name	Designation	Registration NO (PMC/PNC/NCH/ NCT/PMF)	Contact Information

Appendix B: Information of Part Time Doctors/Staff

Name	Designation	Registration NO (PMC/PNC/NCH /NCT/PMF)	Contact Information

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Appendix C: List of Machinery & Equipment

Sr. No	Name of Equipment	Type	Model	Functional/ Non-Functional

Appendix-D

One time Enrolment Fee Schedule

S. No.	Covered Area of Premises	Fee (Rs.)
1	Upto 1000 Sq. Ft.	3,000/-
2	1001-3000 Sq. Ft.	4,000/-
3	More Than 3000 Sq. Ft.	6,000/-