Appendix C:

List of Machinery and Equipment

Sr. No	**Name of Equipment**	**Type**	**Model**	**Functional/ Non-Functional**
(1)	**(2)**	**(3)**	**(4)**	**(5)**

Appendix B:

Information of Part Time Doctors/Staff

Name	Designation	Registration NO (PMC/PNC/NCH/NCT/PMF)	Contact Information
(1)	(2)	(3)	(4)

Appendix A:

Information of Full Time Doctors/Staff

Name	Designation	Registration NO (PMC/PNC/NCH/NCT/PMF)	Contact Information
(1)	(2)	(3)	(4)

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:

2. Instructions:

(a) Fee to be deposited in Islamabad Healthcare Regulatory Authority (IHRA) Current Account No. **1150420000481** in Askari Bank Limited, Kamran Center Branch, Islamabad or such other account as is opened by the Authority for this purpose

(b) Each page shall be signed and stamped by the applicant

(c) Incomplete Form will not be entertained

(d) Provision of incorrect information/documents will result in rejection of application.

(e) Return the completed Form to:

Director Registration IHRA, 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)

C. MEDICAL DIRECTOR/ MEDICAL SUPERINTENDENT		
Name:	Male ☐ ☐ Female	Date Joining _/ /
Title:	Status: ☐ Interim ☐ Acting ☐ Permanent	
Fax:	Landline:	Mobile:
Is the Medical Director in-charge more than one Facility? ☐ Yes ☐ No		
Email:		
Name of Facility, Address and City:		
Professional and Educational Qualifications:		
D. NURSE ADMINISTRATOR (DIRECTOR OF NURSING):		
Name:	Date Joining : _____/_____/_____	
Email:	Landline:	Mobile:
Professional and Education Qualification:		
E. PHARMACY INCHARGE		
Name:	Date Joining: ____/_____/_____	
Email:	Landline:	Mobile:
Professional and Education Qualification:		
F. LABORATORY INCHARGE		
Name:	Date Joining: ____/_____/_____	
Email:	Landline:	Mobile:
Professional and Education Qualification:		

1. Required Documents:

(a) Copy of CNIC of applicant

(b) Declaration attached to this application (Page # 7) should be signed and stamped.

(c) 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.

(d) Appendixes A, B and C to be completed

(e) Fee Deposited Receipt (Refer to Appendix-D)

(f) Receptionist		
8. Pharmacy		
9. Therapists		
(a) Physiotherapist		
(b) Occupational therapist		
(c) Speech therapist		
10. Others		
Total Fulltime Staff:		
Total Part Time Staff:		

K. MANAGEMENT

A. CHIEF EXECUTIVE OFFICER (CEO)/IN-CHARGE/CHIEF OPERATING OFFICER (COO)

Name:		
Title:		
☐ Male ☐ Female	Date Joining: / /	Status: ☐ Interim ☐ Acting ☐ Permanent
Email:	Phone Landline:	Mobile:
Is the CEO/In-charge of more than one Facility? ☐ Yes ☐ No		
If Yes, Name of facility, name and address:		
Professional and Educational Qualification of CEO/IC/COO		

B. PERSON IN-CHARGE IN ABSENCE OF CEO/IC/COO (SUBSTITUTE ADMINISTRATION)

Name:		
Title:		
Contact Details:	Telephone:	Fax:
Professional and Educational Qualifications:		

☐	Renal	☐	Clinical Psychology
☐	Renal dialysis	☐	Nutrition
☐	Rheumatology	☐	Drugs and Alcohol
☐	Reproductive	☐	General Dental
☐	Ambulance	☐	Inpatient Pharmacy
☐	Community/Home	☐	Laboratory - Biochemical
☐	Emergency	☐	Laboratory - Biochemical
☐	Hospice	☐	Laboratory - Microbiology
☐	Long Term Care Unit	☐	Limbs and Prosthetics
☐	Maternity	☐	Orthogenetic
☐	Poly Trauma	☐	Outpatient Pharmacy
☐	Primary Care	☐	Periodontal
☐	Self-Care	☐	Physical Therapy Rehabilitation
☐	Psychiatry	☐	Prosthetic Dental
☐	Homeopathy	☐	Radiology/Imaging (Diagnostic)
☐	Tibb	☐	Radiology
☐	Allied Health	☐	Others
☐	Speech therapy		
☐	Surgical		
☐	Cardiac		

J. STAFFING

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

	FT	PT
1. Board Membership(if applicable)		
2. Management		
3. Medical/Surgical Services		
(a) Consultants		
(b) Medical Officers		
(c) House Officers		
4. Nursing		
5. Post Graduate Students/Residents		
6. Support Services		
7. Allied Health		
(a) LHV		
(b) Technicians		
(c) Midwives		
(d) Physiotherapy Assistant		
(e) Health aide		

Agency: _____ Licence/Certificate/Award:_____
Agency: _____ Licence/Certificate/Award:_____

H. BED CAPACITY

Number of Beds	Male	Female	Total
1. Medical			
2. Surgical			
3. Intensive Care			
4. Neonatal			
5. Operating Room			
6. Emergency Room			
7. Others (Please specify)			
Total			

I. SERVICES

Check if Provided	Service	Check if Provided	Service
☐	Burns	☐	Day surgery
☐	Cardiology	☐	ENT
☐	Communicable	☐	Facio-Maxillary
☐	Dermatology	☐	Gynae
☐	Endocrinology	☐	Head and Neck
☐	Gastrointestinal	☐	Joint Replacement
☐	General	☐	Neurosurgery
☐	Genetics	☐	Obstetric
☐	Genitourinary	☐	Ophthalmological
☐	Geriatrics	☐	Orthopedic
☐	Hematology	☐	Pediatric surgery
☐	Hepatology	☐	Plastic and Reconstructive
☐	Neonatology	☐	Thoracic
☐	Neurology	☐	Transplant
☐	Oncology	☐	Urology
☐	Ophthalmology	☐	Vascular
☐	Pediatric	☐	Additional Specialized Areas
☐	Pain Management	☐	Blood Bank Services
☐	Palliative Care	☐	Chiropody
☐	Pulmonary	☐	Chiropractic

☐ Trust	☐ Limited Liability Company (Public) ☐ Others_____

E. APPLICANT DETAILS

Name:	
Designation: Status: Owner ☐ Manager ☐ In-charge ☐ **(Please tick the relevant box)**	
Qualification:	
PMC/PNC/NCH/NCT Registration No:	
CNIC No: ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	
Mailing Address:	
Landline:	Mobile
Email:	

F. OWNERSHIP DETAILS

Name:	
CNIC No: ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	
Mailing Address:	
Landline:	Mobile

G. EXTERNAL VALIDATION

List all applicable external certificates, Licence, Accreditation, Awards

Agency: _____

Licence/Certificate/Award:_____

SCHEDULE IV

[*See sub-regulation (1) of regulation*]

Forms for Licence of Services

Form No: LIC/IHRA/20 /_____

APPLICATION FOR LICENSING HAVING INDOOR FACILITY

[FORM – 3]

Healthcare Establishments are required to complete this form as per requirements of the provision under Section 22 (I) of the Islamabad Healthcare Regulation 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 (please tick the relevant box)	
☐ Sole Proprietorship	☐ Voluntary Non-Profit
☐ Partnership	☐ Association
☐ Corporation	☐ Limited Liability Company (Pvt)