GOVERNMENT OF PAKISTAN
ISLAMABAD HEALTHCARE REGULATORY AUTHORITY (IHRA)

PRCS-DMLC Building (2nd Floor) Sufi Tabassum Road,
H-8/2, Islamabad.
Ph: 051-9199902

Form No: LIC/IHRA/20 /_____

APPLICATION FOR LICENSING 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 of Healthcare Establishment (HCE):	Longitude: Latitude:
Landline:	Mobile:
Email address:	

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

- ☐ **Teaching**
- ☐ **Non-Teaching**
- ☐ **Single Specialty (please Specify): _____**
- ☐ **Multiple Specialty: _____**
- ☐ **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 of Healthcare Service Provider:

Designation:
Status: Owner ☐ Manager ☐ In-charge ☐
(Please tick the relevant box)

Qualification:

PMDC/PNMC/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 application external certificates, License, Accreditation, Awards:

Agency: _____

License/Certificate/Award _____

Agency: _____

License/Certificate/Award _____

Agency: _____

License/Certificate/Award _____

H. BED CAPACITY

Numbers of Beds	Male	Female	Total
1. Medical			
2. Surgical			
3. Intensive Care			
4. Neonatal			
5. Operating Room			
6. Emergency Room			
7. Others			
Total			

I. SERVICES

Check if provided	Services	Check if provided	Services
☐	Burns	☐	Day Care
☐	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 Area
☐	Pain Management	☐	Blood Bank Services
☐	Palliative Care	☐	Chiropody

☐	Pulmonary	☐	Chiropractic
☐	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 numbers of full time (FT) and part time (PT) employees. Attache additional page 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. Supports Services		

7. Allied Health		
(a) LHV		
(b) Technicians		
(c) Midwives		
(d) Physiotherapy Assistant		
(e) Health aide		
(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:	☐ 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:		

D. MEDICAL DIRECTOR/ MEDICAL SUPERINTENDENT

Name:	Male ☐ Female ☐	Date Joining: / /
Title:	Status: ☐ Interim ☐Acting☐	

	Permanent	
Fax:	Landline:	Mobile:
Is medical director In-Charge more than one facility? Yes ☐ No ☐		
Email:		
Name of Facility, address and city:		
Professional and Educational Qualification:		
D. NURSE ADMINISTRATION (DIRECTOR OF NURSING)		
Name:	Date of Joining: / /	
Email:	Landline:	Mobile:
Professional and Educational Qualification:		
E. PHARMACY INCHARGE		
Name:	Date of Joining: / /	
Email:	Landline:	Mobile:
Professional and Educational Qualification:		
F. LABORTARTY INCHARGE		
Name:	Date of Joining: / /	
Email:	Landline:	Mobile:
Professional and Educational Qualification:		

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.
- Copy of registration of the relevant councils.
- Appendixes A, B and C to be completed
- Fee Deposited Receipt (Refe r 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: 051-9199902** 8:30 am to 4:30 pm working days only)

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 (PMDC/PNMC/ NCH/NCT/PMF)	Contact Information

Appendix B: Information of Part Time Doctors/Staff

Name	Designation	Registration NO (PMDC/PNMC/ NCH/NCT/PMF)	Contact Information

Appendix C: List of Machinery & Equipment

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