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/2024/_____

APPLICATION FOR LICENSE HAVING "NO INDOOR FACILITY"

Healthcare Establishments are required to complete this form as per requirements of the provision under Section 22 (I) 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:	
Landline:	Mobile:
Email address:	

B. TYPE OF HEALTHCARE ESTABLISHMENT		
☐ GP Clinic	☐ Advance Imagining Lab	☐ Homeopath
☐ Single specialty	☐ Imaging Lab	☐ Hakeem
☐ Poly Clinic	☐ Collection Center	☐ Acupuncturist
☐ Laser Clinic	☐ Dental Clinic	☐ Physiotherapist
☐ Cosmetic Surgery Clinic	☐ Maternity Home	☐ Others _____
☐ Pathology Lab	☐ Nursing Home	

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

D. APPLICANT DETAILS	
Name:	
Designation: Status: Owner ☐ Manager ☐ In-charge ☐	
Qualification:	
PMDC/PNMC/NCH/NCT Registration No:	
CNIC No: ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	
Mailing Address:	
Landline:	Mobile
Email:	

E. OWNERSHIP DETAILS	
Name:	
CNIC No: ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	
Mailing Address:	
Landline:	Mobile

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 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 (Original)

Instructions:

- License 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 & Licensing , 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)

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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

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Appendix C: List of Machinery & Equipment

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