Ministry of Healthcare and Nutrition

PRIVATE MEDICAL INSTITUTION REGISTRATION FORM

Registration Form for Full Time Medical Specialist Practices

REGISTRATION NO: _____

To be specified by the Ministry

GENERAL INFORMATION

1. Name of the institution-

2. Address –

3.

a) Name of the person operating/maintaining the institution –
b) The relationship with the institution –

	Address
Official	
Residence	
Private practice	

4. Communication –

Tel. no.	Official	Residence
Fax no.		
Mobile no.		
E-mail		

5. The details of the medical staff including Doctors, Consultants engaged in the medical profession under this institution to be provided as an annexure -

a) Names of the Medical specialists as at the date of application:
b) Names of the Medical Officers
c) Names of the other personnel and the category:
d) Place of permanent employment of the specialist/ Medical Officer/ others:
    a. Government:
    b. Other (Specify):
e) If it is government the name and address of the hospital/ medical institution and the post held by the officer currently:
f) Whether full time or part time
g) Post graduate qualifications and date and the name of degree awarded institute
h) SLMC registration no and date–

6.

Qualifications	Basic	Post Graduation	Year	University	Country

7. Type of practice –

Full time	
Group	
Individual	
Private hospital/ Nursing home	
Other	

8. Hours of practice –

9. Location of practice –

Province	
District	

10. Speciality of practice-

11. Method of record keeping – Computer based record systems ☐
Manual record keeping ☐

12. Emergency kit available or not–

13. Any other facilities (specify): available/ offered

14. Ownership:

Own practice: ☐ Locum: ☐

15. Clinical waste disposal method –

16. Method of sterilization of instruments & dressings –

17. Availability of an appointment system Yes ☐ No ☐

18. Equipment and Facilities (annex a list) available to provide services –

19. If the application is for renewal whether a copy of the existing registration is attached –

20. The number of the existing certificate of registration –

21. The period of the validity of certificate Up to

22. Whether fee is paid, if so the original copy of receipt is attached yes ☐ No ☐

I certify that the above information is true and correct. I further declare that the information furnished by me found to be incorrect or false at any stage my application or certificate of registration can be cancelled or suspended by the authority.

Signature of the person operating or maintaining the institution: -
Name: -
Designation: - Date:

Return after completion through the relevant Provincial Director of Health Services to,

Secretary,
Private Health Services Regulatory Council,
Ministry of Healthcare and Nutrition,
"Suwasiripaya",
385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo - 10.
Sri Lanka.
Tel: 0112674680

The above application is forwarded herewith

Signature Seal ……
The relevant Provincial Director of Health Services Date