



Ministry of Healthcare and Nutrition

REGISTRATION FORM FOR OTHER PRIVATE MEDICAL INSTITUTIONS

REGISTRATION NO:

Official use only

GENERAL INFORMATION

1. Name of the Institution -

2. Address -

3. Communication -

General tel. no.	<input style="width: 100%;" type="text"/>
Fax no.	<input style="width: 100%;" type="text"/>
E-mail	<input style="width: 100%;" type="text"/>
Web site (If available)	<input style="width: 100%;" type="text"/>

4. Location of the institution -

Province	<input style="width: 100%;" type="text"/>
District	<input style="width: 100%;" type="text"/>

5. Name of the person who is operating or maintaining the institution –

- a. Address –
- b. Telephone No (Official): -
(Private): -
- c. The relationship with the institution –

6. **Type of the institution –** *(Tick on appropriate cage)*

- i. Home Care Nursing Services
- ii. Blood Bank
- iii. E-medical Systems
- iv. Other

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7. **Ownership status –** *(Tick on appropriate cage)*

- i. Public company
- ii. Private company
- iii. Other

8. The details of the medical staff including Doctors, Consultants engaged in the medical profession under this institution to be provided as an annexure -
- Names of the Specialists as at the date of application:
 - Names of the Medical Officers:
 - Names of the other personnel and the category:
 - Place of permanent employment of the specialist/ Medical Officer/ others:
 - Government:
 - Other (Specify):
 - Whether full time or part time
 - The Name of the medical college in which the degree was obtained:
 - Country:
 - Basic degree:
 - Post graduate qualifications and date and the name of degree awarded institute
 - SLMC registration no and date:
 - Whether employed in government or not (If employed in government the post held by the officer currently and the place of work):

If there is more than one person working in the institution such details should be submitted as an annexure along with this application.

9. Date of establishment –
10. Company/ Business registration no.-
11. BOI registration (if any) -
12. **HUMAN RESOURCES –**

i. Administrative staff

Designation	Name	Mobile/ Contact tel: no:
Owner/ Chairman		
Medical Director/ In charge Medical Council Reg. no:		
Nursing in charge Medical Council Reg. no:		

ii. Other technical staff and their registration –

13. i. Brief description of services

13. ii. UNITS & FACILITIES

Facilities	Yes/ No	Facilities	Yes/ No
Out Patient Department		CT Scanners	
Consultation rooms		Ultra Sound Scanners	
Emergency Treatment unit		Physiotherapy	
Blood Bank		CSSD	
Fully/ Semi Automated lab		Pharmacy	
Dental Surgery		Waste disposal system	
Cardiology		Patient Record System	
Dialysis unit		Ambulance	
Immunization center		Parking	
Radiology		Training facilities	
MRI Scanners		Others (please specify)	

If more than 01 unit please indicate the number

14. If Radiology and X-Ray facilities are available, the number of the license issued by the Atomic Energy Authority -

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

16. The number of the existing certificate of registration –

17. The period of the validity of certificate

18. 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

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Date