



## Ministry of Healthcare and Nutrition

### Registration Form for Part Time Private General Practices/ Dispensaries/ Medical clinics

**REGISTRATION NO:**

Official use only

#### GENERAL INFORMATION

1. Name of the person operating/ maintaining the institution –
2.
  - a. Address (Official) –
  - b. Address (Private) –
  - c. Telephone No
  - d. The relationship with the institution -
3. Name of the medical institution: –
  - e. Address–
  - f. Telephone no (Official) –
  - g. E-mail –
  - h. Web site –
4. Location of the institution –
 

|          |  |
|----------|--|
| Province |  |
| District |  |
5. The details of the medical staff including Doctors, Consultants engaged in the medical profession under this institution to be provided as an annexure -
  1. Name of the Medical Officer/ specialist as at the date of application:
  2. Name of the Medical College in which the degree was obtained:
  3. Country:
  4. Names of the other personnel and the category:
  5. Place of permanent employment of the specialist/ Medical Officer/ others:
    - a. Government:
    - b. Others (Specify):

(If it is government, the name and address of the hospital/ medical institution and the post held by the officer currently):
6.
  - a) Basic degree:
  - b) The Name of the medical college in which the degree was obtained:
7. Post Graduate qualifications with date and the name of the degree awarding institutions
8. SLMC Registration no and Date:

9. Type of practice: –

|            |                          |
|------------|--------------------------|
| Group      | <input type="checkbox"/> |
| Individual | <input type="checkbox"/> |
| Other      | <input type="checkbox"/> |

10. Hours of practice: –

11. Method of record keeping: – Computer based record systems   
 Manual record keeping   
 Others

12. Facilities for specialists' consultation: –

13. Availability of medical lab: –

14. Dispensary: –

15. Whether Radiology Services available: –

16. If so the number of the license issued by the Atomic Energy Authority -

17. Any other facilities (specify): – Available/ Offered

18. Ownership of premises: –

19. Practicing as a,

General Practitioner:  or Specialist:

If so, what is your speciality?

20. Method of Clinical waste disposal –

21. Method of sterilization of instruments & dressings –

22. Availability of an appointment system? Yes  No

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

24. The number of the existing certificate of registration –

25. The period of the validity of certificate

26. 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  
**The relevant Provincial Director of Health Services**

Seal

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Date