Punjab Healthcare Commission

APPLICATION FOR LICENSE OF HEALTHCARE ESTABLISTMENTS (HCEs)

HCEs Having Indoor Facilities

- Healthcare Establishments are required to complete this form as per the requirements of the provisions of Punjab Healthcare Commission Act 2010.
- **Required Documents;**
  - **Copy of CNIC**
  - **Copy of Degree/ Diploma**
  - **Copy of Updated Registration with relevant Council (PMDC/ PNC/ NCH/ NCT)**
  - **HCE Staff list**
  - **HCE Equipment and Machinery List**
  - **Affidavit on stamp paper (See last page for sample)**
- Incomplete forms will not be entertained.
- Provision of incorrect information/documents will result in rejection of the Application.
- **Return the completed form to:**

  Directorate of Licensing & Accreditation,
  Punjab Healthcare Commission
  185-Ahmad Block, New Garden Town Lahore
- Questions regarding completion of this application may be directed to: **Ph: 042-99333161-68**
- For further information, please visit our web site : www.phc.org.pk

I. GENERAL INFORMATION

A. HEALTHCARE SERVICE PROVIDER

Name:	Designation: _____ Status: Owner ☐ Manager ☐ In-charge ☐	
Qualification:	CNIC Number:	
Registration No. PMDC/ PNC/ NCH/ NCT:		
Mailing Address:		
Town:	City:	District: Punjab
Landline:	Fax:	Email:
Mobile:		

B. HEALTHCARE ESTABLISHMENT

Name:	Date of establishment at present location: (Day/Month/Year)	
Previous Name (If any):		
Mailing Address:		
Town:	City:	District: Punjab
Landline:	Fax:	Email:
Mobile:		

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C. TYPE OF ORGANIZATION

Type of Ownership (please check the appropriate box)

Government	**Others**	
☐ District Government	☐ Sole Proprietary	☐ Voluntary Non- Profit
☐ Provincial Government[1]	☐ Partnership	☐ Association
☐ Federal Government	☐ Corporation	☐ Limited Liability Company (Private)
☐ Autonomous Institution	☐ Trust	☐ Limited Liability Company (Public)

D. TYPE OF HEALTHCARE ESTABLISHMENT (please check the relevant box)

☐ Teaching

☐ Non-Teaching

☐ Single Specialty (please specify): _____

☐ Multiple Specialty

☐ Others _____

_____

E. EXTERNAL VALIDATION

List all applicable external certificates, licenses, accreditation and similar Awards/ Certificate

☐ Agency_____ ☐Award

☐ Agency_____ ☐Award

☐ Agency_____ ☐Award

☐ Agency_____

. ☐ Agency_____

[1]Provincial Government includes Social Security, Aquaf department & Family planning department

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F. SERVICES PROVIDED BY THE HEALTHCARE ESTABLISHMENT			
Check the type of services that are provided, Attach additional pages if necessary			
Check if provided	**Service**	**Check if provided**	**Service**
	Medical		**Surgical**
☐	- Burns	☐	- Cardiac
☐	- Cardiology	☐	- Day surgery
☐	- Communicable diseases	☐	- ENT
☐	- Dermatology	☐	- Facio-maxillary
☐	- Ear Nose & Throat	☐	- General
☐	- Endocrinology	☐	- Gynae
☐	- Gastrointestinal	☐	- Head and neck
☐	- General	☐	- Joint replacement
☐	- Genetics	☐	- Neurosurgery
☐	- Genitourinary	☐	- Obstetric
☐	- Geriatrics	☐	- Ophthalmological
☐	- Haematology	☐	- Orthopaedic
☐	- Hepatology	☐	- Paediatric surgery
☐	- Neonatology	☐	- Plastic and reconstructive
☐	- Neurology	☐	- Thoracic
☐	- Oncology	☐	- Transplant
☐	- Ophthalmology	☐	- Urology
☐	- Paediatric	☐	- Vascular
☐	- Pain management	☐	
☐	- Palliative care	☐	**Others**
☐	- Pulmonary	☐	
☐	- Renal	☐	- Additional Specialized Areas
☐	- Renal dialysis	☐	- Blood Bank Services
☐	- Rheumatology	☐	- Chiropody
☐	- Reproductive	☐	- Chiropractic
☐	*Other*	☐	- Clinical Psychology
☐		☐	- Nutrition
☐	- Ambulance	☐	- Drug and Alcohol
☐	- Community/home based care/immunization	☐	- General Dental
☐	- Emergency	☐	- Inpatient Pharmacy
☐	- Hospice	☐	- Laboratory – Biochemical
☐	- Long Term Care Unit	☐	- Laboratory- Haematology
☐	- Maternity	☐	- Laboratory – Histopathology
☐	- Poly Trauma	☐	- Laboratory – Microbiology
☐	- Primary Care	☐	- Limbs and Prosthetics
☐	- Self-Care Unit/Independent Living Facility	☐	- Orthognathic
☐	- Psychiatry	☐	Outpatient Pharmacy
☐	- Social Work	☐	Periodontal
☐	*Homeopathy*	☐	Physical therapy rehabilitation
☐	*Tib*	☐	Prosthetic dental
☐	*Allied Health*	☐	Radiology/Imaging (diagnostic)
☐	*Speech therapy*	☐	Radiology (therapeutic/intervention)
☐	*Others*		

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G. BED CAPACITY[2]

Please read the explanatory note below. Indicate the total number of beds or treatment spaces actually set up and operational for patient care. If beds are unisex just indicate the total.

Number of Beds	Male	Female	Total
1. Medical			
2. Surgical			
3. Intensive Care			
4. Neonatal			
5. Operating Room			
6. Emergency Room			
7. Others (Please specify)			
Total			

H. OFFSITE LOCATIONS[3]

☐ YES ☐ NO

Name of Offsite Location:	Type of Establishment:
Street Address:	Telephone Number:
City:	Number of Beds:
Services Provided:	

I. STAFFING

Indicate number of full time (FT) and part time (PT) employees. Attach additional pages 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. Support Services		
7. Allied Health		
a. LHV		
b. Technicians		
c. Midwives		
d. Physiotherapy Assistants		
e. Health aide		
f. Receptionist		
8. Pharmacy		
9. Therapists		
a. Physiotherapist		

[2] This section needs to be read and completed with Section F

[3] Offsite locations will include any type of collection centers, laboratories, branch sites etc.

b. Occupational therapist		
c. Speech therapist		
10. Volunteers		
11. Others		
TOTAL Part Time[4]		
TOTAL Full Time[5]		

II. BUILDING PLANS & EQUIPMENTS

A. Building Plans

Do you have building plans? ☐ Yes Complete ☐ Yes but Incomplete ☐ No	
Are building alterations and remodeling proposed in the next 5 years? ☐ Yes ☐ No	
Number of floors:	Residential Accommodation[6]
Number of Generators:	Parking[7]:
Number of Chillers:	

III. MANAGEMENT

A. CHIEF EXECUTIVE OFFICER (CEO)/INCHARGE/CHIEF OPERATING OFFICER (COO)

Name:		
Title:		
☐Male ☐Female	Date Joning:____/_____/_____	Status: ☐Interim ☐Acting ☐ Permanent
Email:	Phone Landline:	Mobile:
Is the CEO/In charge/COO in charge of more than one facility? ☐Yes ☐No		
If yes, Name of facility, address and city: _____		
Professional and Educational Qualifications of the CEO/ IC/ COO		

B. PERSON INCHARGE IN ASBSENCE OF CEO / COO (SUBSTITUTE ADMINISTRATOR)

Name:		
Title:		
Contact Details:	Telephone:	Fax:
Professional and Educational Qualifications		

[4] For Part time staff, please provide additional information as required in Appendix A
[5] For Full time staff, please provide additional information as required in Appendix B
[6] Please provide information in terms of sq ft
[7] Please provide information in terms of sqft

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C. MEDICAL DIRECTOR/MEDICAL SUPERINTENDENT		
Name:	☐ Male ☐ Female	Date Joning ___/____/____
Title:	Status: ☐ Interim ☐ Acting	☐Permanent
Fax:	Landline:	Mobile:
Is the Medical Director in charge of more than one facility? ☐Yes ☐ No		
Email:		
Name Of Facility, Address and City:		
Professional and Educational Qualifications		

D. NURSE ADMINISTRATOR (DIRECTOR OF NURSING)		
Name:	Date Joning: _____/_____/_____	
Email:	Landline:	Mobile:
Professional and Educational Qualifications		

E. PHARMACY INCHARGE		
Name:	Date Joning: _____/_____/_____	
Email:	Landline:	Mobile:
Professional and Educational Qualifications		

F. LABORATORY INCHARGE		
Name:	Date Joning: _____/_____/_____	
Email:	Landline:	Mobile:
Professional and Educational Qualifications		

IV. OWNERSHIP

A. APPLICANT (OWNER)		
Identify person(s) or business entity having the authority to direct the management or policies of the facility.		
Name:		
Street Address:		
Mailing Address (if different from above):		
Town:	City	Punjab
Telephone Number	Fax Number:	Email Address:
Name of Contact Person[8]:		
Title of Contact Person:	Telephone Number:	Cell:
Holding (what the owner owns) ☐ Operations ☐ Building ☐ Land		

B. CHANGE OF OWNERSHIP
List the previous owner's name
Name – Previous Owner:

[8] If different from above

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C. SUBSIDIARY / PARENT INFORMATION		
Is the applicant a subsidiary company, either wholly or partially owned by another organization or business? ☐ **YES** ☐ NO If yes, provide the following information.		
Legal Business name – Parent Company:		
Doing Business As:		
Type of Ownership:		
Mailing Address:		
City	Telephone:	Contact Person:

DECLARATION

I, the undersigned, do hereby solemnly affirm and declare that the HCE _____ provides indoor services and 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 Commission, it may result in rejection of my application for license and I may also be found liable to pay fine to the Commission.

Signature	**Name of Applicant:**
Date Signed:	**Designation:**

Explanatory Notes

I. General Information

A. Healthcare Establishment Location
In the absence of an official establishment email address, please insert the email address of the Establishment CEO/MD/MS/Incharge.

B. External Validation
If the Healthcare Establishment has obtained certification/accreditation from any recognized entity such as ISO, kindly state with the date of award /certification.

C. Services Provided by the Healthcare Establishment
This section is divided into three thematic areas. Kindly check the relevant box(es) for your Healthcare Establishment in each of these categories.

D. Offsite Locations
This section pertains to offsite locations like collection centers, offsite labs, immunization centers, blood banks, practice locations etc. An offsite location is not located or occurring at the site of a particular activity. Add additional pages if necessary.

E. Staffing
For the purposes of fulfilling the requirements of the Punjab Healthcare Commission Act 2010, the Healthcare Establishment must maintain an updated database of all doctors, nurses, technicians and assistants and other medical support staff. Please attach additional sheet with the names, qualifications, PMDC/Nursing Council registration numbers, email addresses and contact numbers of all medical staff.

II. Building Plans

Residential Accommodation pertains to the staff and doctors residing either on the premises of the healthcare establishment or a facility in arrangement with the healthcare establishment.

III. Ownership

Provide details of the owner and Head of Management of Healthcare Establishment. An owner for the purposes of the licensing form shall be a person that possesses the exclusive right to hold, use, benefit-from, enjoy, convey, transfer, and otherwise dispose of an asset or property or an executive who has the principle responsibility for a process, program, or project.

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Appendix A: Information of Full Time Staff

NAME	DESIGNATION	REGISTRATION NUMBER (PMDC/PNC/NCH/NCT/PMF)	CONTACT INFORMATION

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Appendix B: Information of Part Time Staff

NAME	DESIGNATION	REGISTRATION NUMBER (PMDC/PNC/NCH/NCT/PMF)	CONTACT INFORMATION

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Appendix C: List of Electro-Medicel Equipment

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

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Appendix D: List of Machinery

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