



# Punjab Healthcare Commission

## APPLICATION FOR REGISTRATION OF HEALTHCARE SERVICE PROVIDERS

### Category III - HCEs having no 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 (if applicable)
  - HCE Equipment and Machinery List (if applicable)
  - 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  
Office # 1 & 2, 4<sup>th</sup> Floor Shaheen Complex, 38-Abbot Road, Lahore**

- Questions regarding completion of this application may be directed to: Ph. 042 99206371 - 8
- For further information, please visit our web site : [www.phc.org.pk](http://www.phc.org.pk)

### A. HEALTHCARE SERVICE PROVIDER

Name:		Designation: _____	
		Status: Owner <input type="checkbox"/> Manager <input type="checkbox"/> In-charge <input type="checkbox"/>	
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:			



# Punjab Healthcare Commission

C. TYPE OF ORGANIZATION		
Type of Ownership (please check the appropriate box)		
Government	Others	
<input type="checkbox"/> District Government	<input type="checkbox"/> Sole Proprietary	<input type="checkbox"/> Voluntary Non- Profit
<input type="checkbox"/> Provincial Government*	<input type="checkbox"/> Partnership	<input type="checkbox"/> Association
<input type="checkbox"/> Federal Government	<input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company (Private)
<input type="checkbox"/> Autonomous Institution	<input type="checkbox"/> Trust	<input type="checkbox"/> Limited Liability Company (Public)

\*Provincial government includes Social Security, Au qaf department & family planning department etc

D. TYPE OF HEALTHCARE ESTABLISHMENT (please check the relevant box)
<input type="checkbox"/> Single Specialty (please specify): _____
<input type="checkbox"/> Multiple Specialty
<input type="checkbox"/> Others GP Clinic/ Homeopath/ Hakim/ Lab/ Collection Center/ Radiological or Imaging/Maternity or Nursing homes/ Dental clinic/ Cosmetic Surgery/ Laser Clinic/ Physiotherapists/ Acupuncturists/ If any other please specify: _____

## DECLARATION

I, the undersigned, do hereby solemnly affirm and declare that the HCE \_\_\_\_\_ does not provide 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.

<b>Signature</b>	<b>Name of Applicant:</b>
<b>Date Signed:</b>	<b>Designation:</b>







