



# Punjab Healthcare Commission

## APPLICATION FOR LICENSE OF HEALTHCARE ESTABLISHMENTS (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  
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)

### I. GENERAL INFORMATION

#### 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 <sup>1</sup>	<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)

## 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 \_\_\_\_\_

<sup>1</sup>Provincial Government includes Social Security, Aquaf department & Family planning department



# Punjab Healthcare Commission

## 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
	<b>Medical</b>		<b>Surgical</b>
<input type="checkbox"/>	- Burns	<input type="checkbox"/>	- Cardiac
<input type="checkbox"/>	- Cardiology	<input type="checkbox"/>	- Day surgery
<input type="checkbox"/>	- Communicable diseases	<input type="checkbox"/>	- ENT
<input type="checkbox"/>	- Dermatology	<input type="checkbox"/>	- Facio-maxillary
<input type="checkbox"/>	- Ear Nose & Throat	<input type="checkbox"/>	- General
<input type="checkbox"/>	- Endocrinology	<input type="checkbox"/>	- Gynae
<input type="checkbox"/>	- Gastrointestinal	<input type="checkbox"/>	- Head and neck
<input type="checkbox"/>	- General	<input type="checkbox"/>	- Joint replacement
<input type="checkbox"/>	- Genetics	<input type="checkbox"/>	- Neurosurgery
<input type="checkbox"/>	- Genitourinary	<input type="checkbox"/>	- Obstetric
<input type="checkbox"/>	- Geriatrics	<input type="checkbox"/>	- Ophthalmological
<input type="checkbox"/>	- Haematology	<input type="checkbox"/>	- Orthopaedic
<input type="checkbox"/>	- Hepatology	<input type="checkbox"/>	- Paediatric surgery
<input type="checkbox"/>	- Neonatology	<input type="checkbox"/>	- Plastic and reconstructive
<input type="checkbox"/>	- Neurology	<input type="checkbox"/>	- Thoracic
<input type="checkbox"/>	- Oncology	<input type="checkbox"/>	- Transplant
<input type="checkbox"/>	- Ophthalmology	<input type="checkbox"/>	- Urology
<input type="checkbox"/>	- Paediatric	<input type="checkbox"/>	- Vascular
<input type="checkbox"/>	- Pain management	<input type="checkbox"/>	
<input type="checkbox"/>	- Palliative care	<input type="checkbox"/>	<b>Others</b>
<input type="checkbox"/>	- Pulmonary	<input type="checkbox"/>	
<input type="checkbox"/>	- Renal	<input type="checkbox"/>	- Additional Specialized Areas
<input type="checkbox"/>	- Renal dialysis	<input type="checkbox"/>	- Blood Bank Services
<input type="checkbox"/>	- Rheumatology	<input type="checkbox"/>	- Chiropody
<input type="checkbox"/>	- Reproductive	<input type="checkbox"/>	- Chiropractic
<input type="checkbox"/>	<i>Other</i>	<input type="checkbox"/>	- Clinical Psychology
<input type="checkbox"/>		<input type="checkbox"/>	- Nutrition
<input type="checkbox"/>	- Ambulance	<input type="checkbox"/>	- Drug and Alcohol
<input type="checkbox"/>	- Community/home based care/immunization	<input type="checkbox"/>	- General Dental
<input type="checkbox"/>	- Emergency	<input type="checkbox"/>	- Inpatient Pharmacy
<input type="checkbox"/>	- Hospice	<input type="checkbox"/>	- Laboratory – Biochemical
<input type="checkbox"/>	- Long Term Care Unit	<input type="checkbox"/>	- Laboratory- Haematology
<input type="checkbox"/>	- Maternity	<input type="checkbox"/>	- Laboratory – Histopathology
<input type="checkbox"/>	- Poly Trauma	<input type="checkbox"/>	- Laboratory – Microbiology
<input type="checkbox"/>	- Primary Care	<input type="checkbox"/>	- Limbs and Prosthetics
<input type="checkbox"/>	- Self-Care Unit/Independent Living Facility	<input type="checkbox"/>	- Orthognathic
<input type="checkbox"/>	- Psychiatry	<input type="checkbox"/>	Outpatient Pharmacy
<input type="checkbox"/>	- Social Work	<input type="checkbox"/>	Periodontal
<input type="checkbox"/>	<i>Homeopathy</i>	<input type="checkbox"/>	Physical therapy rehabilitation
<input type="checkbox"/>	<i>Tib</i>	<input type="checkbox"/>	Prosthetic dental
<input type="checkbox"/>	<i>Allied Health</i>	<input type="checkbox"/>	Radiology/Imaging (diagnostic)
<input type="checkbox"/>	<i>Speech therapy</i>	<input type="checkbox"/>	Radiology (therapeutic/intervention)
<input type="checkbox"/>	<i>Others</i>		



# Punjab Healthcare Commission

## G. BED CAPACITY<sup>2</sup>

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)			
<b>Total</b>			

## H. OFFSITE LOCATIONS<sup>3</sup>

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		

<sup>2</sup> This section needs to be read and completed with Section F

<sup>3</sup> Offsite locations will include any type of collection centers, laboratories, branch sites etc.



# Punjab Healthcare Commission

b. Occupational therapist		
c. Speech therapist		
10. Volunteers		
11. Others		
<b>TOTAL Part Time<sup>4</sup></b>		
<b>TOTAL Full Time<sup>5</sup></b>		

## II. BUILDING PLANS & EQUIPMENTS

### A. Building Plans

Do you have building plans?	<input type="checkbox"/> Yes Complete	<input type="checkbox"/> Yes but Incomplete	<input type="checkbox"/> No
Are building alterations and remodeling proposed in the next 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Number of floors:	Residential Accommodation <sup>6</sup>		
Number of Generators:	Parking <sup>7</sup> :		
Number of Chillers:			

## III. MANAGEMENT

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

Name:		
Title:		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date Joining: ____/____/____	Status: <input type="checkbox"/> Interim <input type="checkbox"/> Acting <input type="checkbox"/> Permanent
Email:	Phone Landline:	Mobile:
Is the CEO/In charge/COO in charge of more than one facility? <input type="checkbox"/> Yes <input type="checkbox"/> 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


<sup>4</sup> For Part time staff, please provide additional information as required in Appendix A

<sup>5</sup> For Full time staff, please provide additional information as required in Appendix B

<sup>6</sup> Please provide information in terms of sq ft

<sup>7</sup> Please provide information in terms of sqft



# Punjab Healthcare Commission

## C. MEDICAL DIRECTOR/MEDICAL SUPERINTENDENT

Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date Joining ___/___/___
Title:	Status: <input type="checkbox"/> Interim <input type="checkbox"/> Acting <input type="checkbox"/> Permanent	
Fax:	Landline:	Mobile:
Is the Medical Director in charge of more than one facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email:		
Name Of Facility, Address and City:		

### Professional and Educational Qualifications

## D. NURSE ADMINISTRATOR (DIRECTOR OF NURSING)

Name:	Date Joining: ___/___/___
Email:	Landline: Mobile:

### Professional and Educational Qualifications

## E. PHARMACY INCHARGE

Name:	Date Joining: ___/___/___
Email:	Landline: Mobile:

### Professional and Educational Qualifications

## F. LABORATORY INCHARGE

Name:	Date Joining: ___/___/___
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 <sup>8</sup> :		
Title of Contact Person:	Telephone Number:	Cell:
Holding (what the owner owns) <input type="checkbox"/> Operations <input type="checkbox"/> Building <input type="checkbox"/> Land		

### B. CHANGE OF OWNERSHIP

List the previous owner's name
Name – Previous Owner:

<sup>8</sup> If different from above



# Punjab Healthcare Commission

## 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.

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



# Punjab Healthcare Commission

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## 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.







