



Punjab Healthcare Commission

APPLICATION FOR LICENSE FOR HEALTHCARE ESTABLISHMENTS (HCEs)

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, 4th 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

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:		



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C. TYPE OF ORGANISATION

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 ¹	<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)

- Single Specialty (please specify): _____
- Multiple Specialty
- 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: _____

E. SERVICES PROVIDED BY THE HEALTHCARE ESTABLISHMENT

Mention the Healthcare Services Provided;

1. _____
2. _____
3. _____
4. _____
5. _____

II. MANAGEMENT

A. HCE MANAGER/ INCHARGE

Name:

Title:

Male Female

Date of Joining: ____/____/____

Status:

Interim Acting Permanent

Email:

Phone Landline:

Mobile:

Is the HCE Manager/ in charge of more than one facility? Yes No

If yes, Name of facility, address and city:

Professional and Educational Qualifications of the HCE Manager/ Incharge

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



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B. PHARMACY INCHARGE (If Applicable)			
Name:		Date of Joining: ___ / ___ / ___	
Email:	Landline:	Mobile:	
Professional and Educational Qualifications			
C. LABORATORY INCHARGE (If Applicable)			
Name:		Date of Joining: ___ / ___ / ___	
Email:	Landline:	Mobile:	
Professional and Educational Qualifications			
III. OWNERSHIP			
A. APPLICANT (OWNER)			
Identify person(s) or business entity having the authority to direct the management or policies of the facility.			
Name:			
Address:			
Mailing Address if different from above Address:			
Town:	City	Punjab	
Telephone Number	Fax Number:	Email Address:	
Name of Contact Person:			
Title of Contact Person:	Telephone Number:	Mobile:	
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:			

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.

Signature	Name of Applicant:
Date Signed:	Designation:



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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/MS/MD/Incharge.

B. 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. 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, 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.

