Ministry of Healthcare and Nutrition

Registration Form for Full Time Private General Practices/ Dispensaries/ Medical clinics

REGISTRATION NO: _____

Official use only

GENERAL INFORMATION

1. Name of the person operating/ maintaining the institution -
    a. Address (Official) –
    b. Address (Private) –
    c. The relationship with the institution -

2. Name of the medical institution: –
    a. Address–
    b. Telephone (Official) –
    c. E-mail –
    d. Web site –

3. Location of the institution –

Province	
District	

4. The details of the medical staff including Doctors, Consultants engaged in the medical profession under this institution to be provided as an annexure -
    a) Names of the specialists as at the date of application:
    b) Names of the Medical Officers:
    c) Names of the other personnel and the category:
    d) Place of permanent employment of the specialist Medical Officer/ others:
        a. Government
        b. Other (Specify)
    e) Whether full time or part time:
    f) The name of the medical college in which the degree was obtained:
    g) Country:
    h) Basic degree:
    i) Post Graduate qualifications and date and the name of degree awarded institute:
    j) SLMC Registration no and Date:

5. Place of permanent employment of the specialist Medical Officer/ others:
    a. Government:
    b. Other (Specify):

If it is government the name and address of the hospital/ medical institution and the post held by the officer currently:

6. Type of practice: –

Group	
Individual	
Other	

7. Hours of practice: –

8. Method of record keeping: –

Computer based record systems	
Manual record keeping	
Others	

9. Facilities for specialists consultation: –

10. Availability of medical lab: –

11. Dispensary: –

12. Radiology Services: –

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

14. Any other facilities (specify): –

15. Ownership of premises: –

16. Practicing as a,

General Practitioner: ☐ or Specialist: ☐

If so, what is your speciality?

17. Method of Clinical waste disposal –

18. Method of sterilization of instruments & dressings –

19. Availability of an appointment system? Yes ☐ No ☐

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

21. The number of the existing certificate of registration –

22. The period of the validity of certificate Up to

23. 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 Seal ……

The relevant Provincial Director of Health Services Date