

Ministry of Healthcare and Nutrition

REGISTRATION FORM FOR MEDICAL CENTRES/ SCREENING CENTRES/ DAY CARE MEDICAL CENTRES/ CHANNEL CONSULTATIONS

	COTTOCI	_	
	REG	SISTRATION NO:	
			Official use only
GE	ENERAL INFORMATION		
1.	Name of Institution -		
2.	Address -	3. Communica	ntion -
		General tel. no.	
		Fax no.	
		E-mail	
		Web site (If available)	
4.	Location of the institution -		
	Province		
	District		
5.	Name of the person who is operating or	maintaining the institu	ution –
	a. Address (Official) –		
	b. Telephone No (Office): -		
	(Residence): -	·	
	c The relationship with the institu	tion –	
6.	The details of the medical staff incl-	uding Doctors Consu	Itants engaged in the
-	dical profession under this institution to	_	0 0
1110	a) Names of the Specialists as at the da	-	chare
	b) Names of the Medical Officers	T	
	c) Names of the other personnel and t	he category:	
	d) Place of permanent employment of		l 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:	1.1 (.1	1 11
	i) Post graduate qualifications and dat	e and the name of deg	ree awarded institute

j) SLMC registration no and date-

	held b	by the officer currently and	the place of work):
7.	Type of the institution – (Tick on appropriate cage)		
	i. ii. iii. iv. iv.	Medical Centre Screening Centre Day care Medical Centre Channel Consultation Other	
8.	Ownership status – (Tick on appropriate cage)		
	i. ii.	Public company Private company	
	iii.	Other	
9.	Date of	of establishment –	
10.	Comp	any/ Business registration 1	no
11.	BOI re	egistration (if any) -	

k) Whether employed in Government or not (If employed in Government the post

12. **HUMAN RESOURCES –**

Administrative staff

Designation	Name	Mobile/ Contact tel: no:
Owner/ Chairman		
Medical Director/ In charge		
Medical Council Reg. no:		
Nursing in charge		
Medical Council Reg. no:		

13. UNITS & FACILITIES

Facilities	Yes/ No	Facilities	Yes/ No
Out Patient Department		Ultra Sound Scanners	
Consultation rooms		Physiotherapy	
Emergency Treatment unit		CSSD	
Blood Bank		Pharmacy	
Fully/ Semi Automated lab		Waste disposal system	
Dental Surgery		Patient Record System	
Cardiology		Ambulance	
Dialysis unit		Parking	
Immunization center		Training facilities	
Radiology		Others (please specify)	
MRI Scanners			
CT Scanners			

If more than 01 unit please indicate the number

Health PHSRC 09

14.	The number of the license issued by the Atomic Energy Authority -			
15.	If the application is for renewal whether a copy of the existing registration is uched –			
16.	The number of the existing certificate of registration –			
17.	The period of the validity of certificate Up to			
18.	Whether fee is paid, if so the original copy of receipt is attached yes No			
inform	ify that the above information furnished by me found tificate of registration can be constituted.	to be incorre	ect or false at any stage, n	ny application
Signature of the person operating or maintaining the institution: - Name: - Designation: - Date:				
Return	after completion through the	relevant Prov	rincial 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			Iawatha,
The above application is forwarded herewith				
Signatu The re	are Seal Elevant Provincial Director o	of Health Ser	vices	Date