# Ministry of Healthcare and Nutrition

## REGISTRATION FORM FOR PRIVATE HOSPITALS, NURSING HOMES AND MATERNITY HOMES

**REGISTRATION NO:** [ ]

Official use only

### GENERAL INFORMATION

1. Name of the Institution - [ ]

2. Address - [ ]

3. Communication -

| General tel. no. | |
|---|---|
| Fax no. | |
| E-mail | |
| Web site (If available) | |

4. Name of the person operating/ maintaining the hospital -
   a. Address -
   b. Telephone -
   c. The relationship with the institution -

5. Location of the hospital – (Attach a photograph of the hospital if available -front view)

| Province | |
|---|---|
| District | |

6. **Type of the institution –** *(Tick on appropriate cage)*

   i. Private hospital [ ]
   ii. Nursing home [ ]
   iii. Maternity home [ ]

   iv. Other …………..

7. **Ownership status –** *(Tick on appropriate cage)*

   i. Public company [ ]
   ii. Private company [ ]
   iii. Proprietary private hospital [ ]
   iv. Co-operative hospital [ ]
   v. Estate owned hospital [ ]

   vi. Other …………..

8. Date of Establishment – [ ]

9. Company/ Business registration no.- [ ]

10. BOI registration - [ ]

11. HUMAN RESOURCES -

| Designation | Name | Mobile/ Contact tel: no: |
|---|---|---|
| Owner/ Chairman | | |
| Managing Director/ CEO | | |
| Medical Director/ In charge<br>Medical Council Reg. no: | | |
| Administrative Officer | | |
| Nursing Director/ Matron<br>Medical Council Reg. no: | | |
| Accountant/ Finance Director | | |
| Human Resources Manager | | |
| Others | | |

12. The details of the medical staff including Doctors, Consultants engaged in the 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:

13. 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 or medical institution and the post held currently:

14. Method of record keeping -

15. UNITS & FACILITIES

   Total no: of inpatient beds - [ ]

   Total No. of rooms/ wards –
   Rooms [ ]
   Wards [ ]

| Facilities | Yes/ No | Facilities | Yes/ No |
|---|---|---|---|
| Out Patient Department | | Immunization center | |
| Consultation rooms | | Radiology | |
| Emergency Treatment unit | | MRI Scanners | |
| Intensive Care unit | | CT Scanners | |
| Surgical Intensive Care unit | | Ultra Sound Scanners | |
| Medical Intensive Care unit | | Physiotherapy | |
| Neurological Intensive care unit | | CSSD | |
| High Dependency unit | | Pharmacy | |
| Coronary Care unit | | Waste Disposal System | |
| Operating theatre | | Patient Record System | |
| Blood Bank | | Ambulance | |
| Labour room | | Parking | |
| Fully/ Semi Automated lab | | Training facilities | |
| Dental Surgery | | Mortuary | |
| Cardiology | | Others (please specify) | |
| Dialysis unit | | | |

*If more than 01 unit please indicate the number*

16. i. The availability of the license obtained from the Atomic Energy Authority for Radiology Service:
    Yes ☐ No ☐

    ii. The number of such license -

17. Method of clinical waste disposal -

18. Method of sterilization of instruments and dressings -

19. Emergency kit -available or not

20. Equipment and facilities (annex a list) available to provide services -

21. Any other facility (specify) - available/ offered

22. If the application is for renewal whether a copy of the existing registration is attached -

23. The number of the existing certificate of registration -

24. The period of the validity of certificate: Up to

25. 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 suspend 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",
Colombo - 10.
Tel: 0112674680

The above application is forwarded herewith

Signature Seal ……………
**The relevant Provincial Director of Health Services** Date