Ministry of Healthcare and Nutrition

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

REGISTRATION NO: _____

Official use only

GENERAL INFORMATION

1. Name of Institution - _____

2. Address - _____

3. Communication -

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 institution –
   a. Address (Official) –
   b. Telephone No (Office): -
      (Residence): -
   c The relationship with the institution –

6. 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–

k) Whether employed in Government or not (If employed in Government the post held by the officer currently and the place of work):

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

i. Medical Centre ☐
ii. Screening Centre ☐
iii. Day care Medical Centre ☐
iv. Channel Consultation ☐
iv. Other …….

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

i. Public company ☐
ii. Private company ☐

iii. Other ……..

9. Date of establishment – ☐

10. Company/ Business registration no.- ☐

11. BOI registration (if any) - ……..

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

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 attached –

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 ☐

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