



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 Medical Council Reg. no:		
Administrative Officer		
Nursing Director/ Matron 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 -
- Names of the specialists as at the date of application:
 - Names of the Medical Officers:
 - Names of the other personnel and the category:
 - Place of permanent employment of the specialist Medical Officer/ others:
 - Government
 - Other (Specify)
 - Whether full time or part time:
 - The name of the medical college in which the degree was obtained:
 - Country:
 - Basic degree:
 - Post Graduate qualifications and date and the name of degree awarded institute:
 - SLMC Registration no and Date:

13. Place of permanent employment of the specialist Medical Officer/ others:
- Government:
 - 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	<input type="text"/>
Wards	<input type="text"/>

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:

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