Khyber Pakhtunkhwa Health Care Commission

--------------------------------------------------------------Government of Khyber Pakhtunkhwa

**APPLICATION FOR GRANT OF LICENSE TO HEALTH CARE ESTABLISHMENTS**

**Instruction:**

1. Please fill the form carefully, incomplete form will not be entertained
2. Provide the evidence where required.
3. Attach the required documents (as per check list given on page 12)

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| 1. **GENERAL INFORMATION**
 |
|  |
| 1. **Details of HCE**
 |
| **Name:**  | **Previous if Any:**  |
| **KP-HCC Registration Number:**  |
| **Registration Number Issued by any Other Regulatory Body:**  |
| **Address:**  |
| **No. of Beds.** |  |
| **Contact Number:**  | **Fax:**  |
| **Email:** | **Website:**  |
| **Date of Establishment** | **Date of First KP HCC Registration** |

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| 1. **Type of Ownership**
 |
| **Public**  | **Private**  | **PPP (Mention Details)** | **Others (Describe)** |
| 🞎 Federal Government🞎 Provincial Government🞎 District/Municipal Govt:🞎 Autonomous Body | 🞎 Sole Proprietorship🞎 Partnership🞎 Company/Corporation🞎 Association🞎 Voluntary/NPO🞎 Trust🞎 Charity |  |  |

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| 1. **Details of Owner(s) [[1]](#footnote-1)**
 |
| **Name:**  | **Father Name:** |
| **Designation in HCE** | **CNIC** |
| **Address:**  |
| **Mailing Address:**  |
| **Phone Number:**  | **Fax:**  |
| **Email:** |  |

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| 1. **Category**
 |
| 🞎 Cat-1 🞎 Cat-2A 🞎 Cat-2B  |

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| 1. **Status/Type**
 |
| 1. 🞎 In-door 🞎 Out-door
 |
| 1. 🞎 Teaching 🞎 Non-Teaching
 |
| 1. 🞎 Primary 🞎 Secondary 🞎 Tertiary
 |
| 1. Sehat Card empanelment: 🞎 Yes 🞎 No
 |

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| 1. **Accreditation/Validation**
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| Agency: | Accreditation | Date |
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| 1. **BUILDING PLAN & MACHINERY**
 |
| Total Area: | Covered Area: |
| Green Area: | Parking Area: |
| Number of Floors: | Number of Wards: |
| Number of Rooms | OPD Clinics: |
| Non-Medical Facilities/Rooms: | OT’s:  |
| Recovery Rooms | ICU/CCU/HDU |
| Lift | Ramp: |
| MIS:  | Surveillance:  |
| Cafeteria | Washrooms: |
| Pharmacies | Waiting Area:  |
| Fire Extinguisher(s) | Waste Management:  |
| Electric generators: | Solar System: |
| Air Conditioning: | Water Filters/Chillers: |
| Residential Accommodation: | Others:  |

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| 1. **DETAILS OF SERVICES**
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| **Check** | **Service** | **Check** |  |
| 🞎 | Burns | 🞎 | Ambulance |
| 🞎 | Hematology | 🞎 | Blood Bank Services |
| 🞎 | Interventional Cardiology | 🞎 | Cardiac Surgery |
| 🞎 | Neurology | 🞎 | Clinical Psychology |
| 🞎 | Ophthalmology | 🞎 | Day surgery |
| 🞎 | Pediatric | 🞎 | Dental |
| 🞎 | Rheumatology | 🞎 | Diagnostic Laparoscopy  |
| 🞎 | Allied Health (Acupuncture / acupressure) | 🞎 | General Surgery |
| 🞎 | Day Care Clinic | 🞎 | Head and neck Surgery  |
| 🞎 | Fertility Clinic | 🞎 | Inpatient Pharmacy |
| 🞎 | Fetomaternal Medicine | 🞎 | Joint replacement |
| 🞎 | Immunization | 🞎 | Laboratory — Biochemical |
| 🞎 | NICU | 🞎 | Laboratory — Histopathology |
| 🞎 | Renal dialysis | 🞎 | Laboratory — Microbiology |
| 🞎 | Medical ICU | 🞎 | Laboratory- Hematology |
| 🞎 | Cardiology | 🞎 | Laparoscopic Surgery |
| 🞎 | Accident & Emergency | 🞎 | Limbs and Prosthetics |
| 🞎 | Palliative care | 🞎 | Maxillofacial |
| 🞎 | Community/home based care | 🞎 | Neurosurgery |
| 🞎 | Communicable diseases | 🞎 | Nutrition |
| 🞎 | Ear Nose & Throat | 🞎 | Ophthalmological |
| 🞎 | Endocrinology | 🞎 | Organ Transplantation |
| 🞎 | Gastroenterology | 🞎 | Orthodontic |
| 🞎 | Hospice | 🞎 | Orthopedic |
| 🞎 | General | 🞎 | Otorhinolaryngology |
| 🞎 | Long Term Care Unit | 🞎 | Outpatient Pharmacy |
| 🞎 | Primary Care | 🞎 | Pediatric surgery |
| 🞎 | Maternity Care | 🞎 | Pediatric/ Cardiac Surgery |
| 🞎 | Pain management | 🞎 | Periodontal |
| 🞎 | Dermatology | 🞎 | Physiotherapy / Rehabilitation |
| 🞎 | Self-Care Unit/Independent Living Facility | 🞎 | Plastic and reconstructive |
| 🞎 | Genetics | 🞎 | Prosthetic dental |
| 🞎 | HDU | 🞎 | Radiology (therapeutic/intervention) |
| 🞎 | Genitourinary | 🞎 | Radiology/Imaging (diagnostic) |
| 🞎 | Geriatrics | 🞎 | Rehab (Drug) |
| 🞎 | Oncology | 🞎 | Spine Surgery |
| 🞎 | Social Work | 🞎 | Surgical ICU |
| 🞎 | Pulmonology | 🞎 | Thoracic |
| 🞎 | Physiotherapy | 🞎 | Urology |
| 🞎 | Endoscopy | 🞎 | Endoscopic Surgery |
| 🞎 | Psychiatry | 🞎 | Obstetric |
| 🞎 | Hepatology | 🞎 | Vascular |
| 🞎 | Nephrology | 🞎 | Speech therapy |
| 🞎 | Homeopathy | 🞎 | Tibb/Hikmat |
| 🞎 | Neonatology | 🞎 | Trauma Center |
| 🞎 | ***Other***  | 🞎 | Urogynaecology |

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| 1. **BED CAPACITY**
 |
| **Facility Male Female Total** |
| 1. Medical & Allied
 |  |  |  |
| 1. Surgical & Allied
 |  |  |  |
| 1. ICU/CCU/HDU
 |  |  |  |
| 1. Neonatal/NICU
 |  |  |  |
| 1. OTs Tables
 |  |  |  |
| 1. Emergency Room
 |  |  |  |
| 1. Space allocated for special persons[[2]](#footnote-2)
 |  |  |  |
| 1. Others (Please specify)
 |  |  |  |

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| 1. **Number of STAFF**
 |
|  | **Section** | **Full Time** | **Part Time** | **Total** |
| M | F | M | F |  |
| 1 | Board | - | - | - | - |  |
| 2 | Managerial / Admin |  |  |  |  |  |
| 3 | Medical/Surgical |  |  |  |  |  |
| Teaching Staff |  |  |  |  |  |
| Consultants |  |  |  |  |  |
| Medical Officers |  |  |  |  |  |
| TMO’S |  |  |  |  |  |
| House Officers |  |  |  |  |  |
| 4 | Para Medical |  |  |  |  |  |
| 5 | Nursing |  |  |  |  |  |
| 6 | Engineering |  |  |  |  |  |
| 7 | Pharmacy |  |  |  |  |  |
| 8 | Support Services |  |  |  |  |  |
| 9 | Security  |  |  |  |  |  |
| 10 | Sanitation |  |  |  |  |  |
|  | Others (Specify) |  |  |  |  |  |
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| 1. **SENIOR MANAGEMENT**
 |
| 1 | **Chairman Board:** Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 2 | **Chief Executive Officer/Executive Director:**  Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 3 | **Chief Operating Officer/Hospital Director:**Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 4 | **Medical Director etc:**Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 5 | **Nursing Director:** Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 6 | **Chief Pharmacist:** Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 6 | **Incharge Quality:**Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 8 | **Incharge Engineering:** Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 8 | **Chairperson Complaint Redressal Committee**Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 9 | **Incharge Information Technology Deptt:** Name:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status: 🞎 Regular\_\_🞎\_ActingPlaces of Work: 🞎 Single\_\_🞎\_MultipleName (s) of Facility(ies) in case of work at multiple places: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educational Qualification: Professional Experience: Contact: Phone: Mobile: Email:  |
| 10 | **Others:** |

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| 1. **SUBSIDIARY/PARENT INFORMATION**
 |
| * Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

 🞎YES 🞎NO* If yes, provide the following information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Legal Business name —
* Parent Company:
* Doing Business As:
* Type of Ownership:
* Address:
* City
* Telephone: Contact Person:
 |

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| 1. **CHANGE OF NAME/ ADDRESS/ OWNERSHIP**
 |
| * Name of Previous Owner:
* Previous Address:
* Previous Name:
* Date of Change of Name/ address/ Ownership
 |

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| 1. **0FF-SITE LOCATIONS**
 |
|  🞎 YES 🞎 NO 🞎 No of offsite location: |

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| --- | --- |
| Name of Offsite Location: | Type of Establishment: |
| Street Address: | Telephone Number: |
| City: | Number of Beds: |
| Services Provided: |

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| 1. **DETAILS OF THE APPLICANT**
 |
| **Name:**  | **Father Name:** |
| **Designation:** | **CNIC No:** |
| **Contact No:** | **Emergency Contact No:** |
| **Mailing Address:** | **Email:**  |

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| 1. **INFORMATION OF FULL TIME STAFF**
 |
| **No** | **Name**  | **Designation** | **Qualification** | **Registration No of the relevant regulatory body (PMDC, PNC etc.)** | **Contact No /Email** |
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| 1. **INFORMATION OF PART TIME STAFF**
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| **No** | **Name** | **Designation** | **Qualification** | **Registration No of the relevant regulatory body (PMDC, PNC etc.)** | **Contact No /Email** |
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| 1. **INFORMATION OF MACHINERY AND EQUIPMENT**
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| **Bio Medical** | **Other**  |
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1. **DECLARATION**

**(To be filled on Stamp paper worth PKR. 100)**

I, ………………………............................, do hereby solemnly affirm and declare that the ……………………………………………. (HCE) is providing services and the information provided above is true and correct to the best of my knowledge and belief and that nothing has been concealed. I also undertake that if any false or incorrect information is provided to the Commission, it may result in rejection of my application for license and I may also be found liable to pay fine to the Commission.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CNIC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1. **CHECK LIST OF DOCUEMENTS TO BE ATTACHED**
 |
| 🞎 | Copy of NIC and passport size picture of Applicant/owner |
| 🞎 | Copy of Registration Certificates of HCC and other relevant regulatory bodies such as FBR, SECP, Social Welfare Department and/or others |
| 🞎 | Copies of rent agreement/ownership certificate of the building with lay out plan |
| 🞎 | Copies of agreements of out sourced services. E.g. waste management, radiological services, clinical pathology etc. |
| 🞎 | Affidavit on stamp paper  |
| 🞎 | Fee deposit slip  |

**NOTE: LICENSING FEE SHOULD BE DEPOSITED IN ANY Bank of Khyber**

**Name of Bank:** Bank of Khyber

**Account Title:** Registration (KP HCC)

**Account No:** 0001002007476817

Fee Deposited Amount (in figures) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Amount in words) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Receipt No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the depositor (as per bank receipt): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the BOK branch where fee deposited: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In case of multiple owners, add more rows [↑](#footnote-ref-1)
2. Special persons mean Poor people, transgender and persons under physical and mental disabilities [↑](#footnote-ref-2)