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**
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| 1. **Details of HCE**
 |
| **Name:**  | **Previous if Any:**  |
| **KP-HCC Registration Number:**  |
| **Registration Number Issued by any Other Regulatory Body:**  |
| **Address:**  |
| **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**

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| **Category** | **Scope of Services/Type of Tests** | **Qualification of the Lab Director/Technical****Head for Supervision** |
| **A** | Immunology, PCR Histopathology,Genetic testing, AdvancedHematology, Enzyme / Hormonestudies, Tissue typing, etc. | 1. RMP with recognized post-graduation inany branch of pathology as technicalhead2. Subject specialist pathologist or scientistas section heads3. Full time director/technical head4. Per shift section heads as per workload |
| **B** | Microbiology (C/S, etc.), ChemicalpathologyELISA/ Immunoassay | 1. RMP with recognized medium (M-Phil)degree in any branch of pathology astechnical head2. Technologist or scientist or pathologistas section heads as per work load |
| **C** | Routine clinical lab tests | 1. RMP with recognized diploma/equivalent PG qualification |

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| 🞎 Cat-A 🞎 Cat-B 🞎 Cat-C  |

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| 1. **Accreditation/Validation**
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| Agency: | Accreditation | Date |
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| 1. **BUILDING PLAN & MACHINERY**
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| Total Area: | Covered Area: |
| Lift | Ramp: |
| MIS:  | Surveillance:  |
| Fire Extinguisher(s) | Waste Management:  |
| Electric generators: | Solar System: |
| Air Conditioning: | Water Filters/Chillers: |

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| 1. **DETAILS OF SERVICES**
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| **Yes** | **No** |  |
| 🞎 | 🞎 | Home Sample Vehicle |
| 🞎 | 🞎 | Blood Bank Services |
| 🞎 | 🞎 | Laboratory — Biochemical |
| 🞎 | 🞎 | Laboratory — Histopathology |
| 🞎 | 🞎 | Laboratory — Microbiology |
| 🞎 | 🞎 | Laboratory- Hematology |

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| 1. **Number of STAFF**
 |
|  | **Section** | **Full Time** | **Part Time** | **Total** |
| M | F | M | F |  |
| 1 | Pathologist | - | - | - | - |  |
| 2 | Managerial / Admin |  |  |  |  |  |
| 3 | Lab Technicans |  |  |  |  |  |
| 4 | Engineering |  |  |  |  |  |
| 5 | Support Services |  |  |  |  |  |
| 6 | Security  |  |  |  |  |  |
| 7 | Sanitation |  |  |  |  |  |
|  | Others (Specify) |  |  |  |  |  |
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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: |  |
| Services Provided: |
| 1. **Collection Points (if any)**
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|  🞎 YES 🞎 NO 🞎 No of Collection Points: |
| Collection Points Location: |  |
| Telephone Number: |  |
| City: |  |

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

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| 1. **INFORMATION OF FULL 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 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**
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| 🞎 | 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 / MOU with other laboratories 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)