Khyber Pakhtunkhwa Health Care Commission

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

**APPLICATION FOR GRANT OF LICENSE DENTAL CLINICS**

This form is applicable to each individual practicing as Dental Surgeon & Specialist Dental Surgeon in a clinic (independently).

**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 05)

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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:**  |
| **Contact Number:**  | **Fax:**  |
| **Email:** | **Website:**  |
| **Date of Establishment** | **Date of First KP HCC Registration** |

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

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| 1. **Government Job**
 |
| **Job Title** | **Organization/ Healthcare Establishment name** | **Pay Scale** |  |
|  |  |  |  |

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| 1. **Details of Health Care Service Provider**
 |
| **Name:**  | **Father Name:** |
| **PMDC Registration No:** | **CNIC** |
| **Qualification:**  |
| **Mailing Address:**  |
| **Phone Number:**  | **Email:** |

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| 1. **Details of Owner [[1]](#footnote-1)**
 |
| **Name:**  | **Father Name:** |
| **PMDC Registration No (If any):** | **CNIC** |
| **Qualification:**  |
| **Mailing Address:**  |
| **Phone Number:**  | **Fax:**  |
| **Email:** |  |

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

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| 1. **Number of STAFF**
 |
|  | **Section** | **Full Time** | **Part Time** | **Total** |
| M | F | M | F |  |
| 1 | Managerial / Admin |  |  |  |  |  |
| 2 | Support Services/Technicians |  |  |  |  |  |
| 3 | Security |  |  |  |  |  |
| 4 | Sanitation |  |  |  |  |  |
|  | Others (Specify) |  |  |  |  |  |
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| 1. **Timing of clinic + Days**
 |
| **Days** | **From** | **To** |
| Monday |  |  |
| Tuesday |  |  |
| Wednesday |  |  |
| Thursday |  |  |
| Friday |  |  |
| Saturday |  |  |
| Sunday |  |  |

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

1. **DECLARATION**

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

I, ………………………............................, do hereby solemnly affirm and declare that the ……………………………………………. (HCE/Clinic) 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. It is further stated that;

1. No service other than those registered with Khyber Pakhtunkhwa Health Care Commission shall be provided.
2. The Healthcare facility will not be used for quackery, immoral and illegal activities.
3. Only qualified practitioner registered with KPHCC and their respective council shall provide services at the healthcare establishment.

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 PMDC, FBR, SECP(if any), Social Welfare Department(if any) 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 laboratories and other diagnostic HCEs 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)