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The Gazette of the Democratic Socialist Republic of Sri Lanka
EXTRAORDINARY

අංක 1521/26 – 2007 නොවැම්බර් 02 වැනි සිකුරාදා – 2007.11.02
No. 1521/26 – FRIDAY, NOVEMBER 02, 2007

(Published by Authority)

PART I : SECTION (I) — GENERAL

Government Notifications

L.D.B. 8/2006.

PRIVATE MEDICAL INSTITUTIONS (REGISTRATION) ACT, No. 21 OF 2006

REGULATIONS made by the Minister of Healthcare and Nutrition under Section 18 read with Section 3 of the Private Medical Institutions (Registration) Act, No. 21 of 2006.

NIMAL SIRIPALA DE SILVA,
Minister of Healthcare and Nutrition.

Colombo,
1st November, 2007.

Regulations

The Private Medical Institutions (Registration) Regulations No. 01 of 2007 published in *Gazette Extraordinary* No. 1489/18 of March 22, 2007 is hereby amended by the substitution of Annexure I to XI of Schedule A thereof of the following new Annexure I to XI therefore.

Annexure I

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 relatoinship 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 —

Administrative Staff

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 :-
   (*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 :

13. Place of permanent employment of the specialist Medical Officer/others :
   (*a*) Government :-
   (b) Other (Specify) :-
   If it his government the name and address of the hospital or medical institution and the post held currently :

14. Method of record keeping :-

15. Units and Facilities :

   Total No. of inpatient beds—

   Total No. of rooms/wards—

      Rooms

      Wards

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		Mortuary	
Dental Surgery		Training Facilities	
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 cetificate of registrtion :-
24. The period of the validity of certificate : Up to
25. Whether fee is paid, if so the 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 :-

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

..... Seal .....

Signature *Date*

The relevant Provincial Director of Health Services

(If available)

Annexure I I

Ministry of Healthcare and Nutrition

Registration Form for Private medical laboratories

Registration No. [ ]
Official use only

GENERAL INFORMATION

1. Name of the Medical Lab :
2. (*a*) Address :-
   (*b*) Telephone. No :-
   (*c*) E-mail :-
3. (*a*) Name of the person operating/maintaing the lab :-
   (*b*) the relationship with the lab :-
   (*c*) Address :-
   (*d*) General Telephone No :-
   (*e*) Fax No :-
   (*f*) E-mail Address :-
   (*g*) Web site Address (If available) :-
4. Location of the lab :-

Province	
District	

5. Type of the Lab

(*a*) Automated	
(*b*) Semi Automated	
(*c*) Mobile lab	
(*d*) Collecting Centers	

6. Ownership status — *(Tick on appropriate cage)*

(*a*) Public Company	
(*b*) Private Company	
(*c*) Proprietary Private Hospital	
(*d*) Co-operative Hospital	
(*e*) Estate owned Hospital	
(*f*) Other	
(*g*) Date of Establishment	
(*h*) Business Registration No	

7. (i) Administration staff—

Designation	*Name*	*Contact Tel. No.*
Chairman	.....	
CEO/Managing Director	.....	
Administrative Officer	.....	
Accountant	.....	
Other Major Staff	.....	

(ii) The details of the medical staff including Doctors, Consultants engaged in the profession under this institution to be provided as an annexure :-

Lab staff—

1. Pathologist :-
2. MLTT (SLMC Registration No.) :-
3. Qualifications :-
4. SLMC Registration No :-
5. The Country and the Medical College where the Degree/Post Graduation was obtained :-

(iii) Whether employed in government or private :-
If government the name of the medical institution and the post held currently :

8. Facilities Available :-
9. Machinery/equipment availabe :-
(*a*) Medical machinery :-
10. Method of waste disposal :-
11. Whether Radiology facilities are available :-
12. If so, the number of the licence issued by the Atomic Energy Authority :-
13. If the application is for renewal whether a copy of the existing registration is attached :-
14. The number of the existing cetificate of registrtion :- _____
15. The period of the validity of certificate : Up to
16. Whether fee is paid, if so the 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 :-

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
The relevant Provincial Director of Health Services.

Seal

Date

Annexure III

Ministry of Healthcare and Nutrition

Registration Form for Full Time Private General Practices / Dispensaries / Medical Clinics

Registration No. : [ ]
Official use only

GENERAL INFORMATION

1. Name of the person operating/maintaining the institution :-
   (*a*) Address (Official) :-
   (*b*)Address (Private) :-
   (*c*)The relationship with the institution :-

2. (*a*) Name of the medical institution :-
   (*b*) Address :-
   (*c*) Telephone (Official) :-
   (*d*) E-mail :-
   (*e*) Web Site :-

3. Location of the institution :-

Province	
District	

4. 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*) Name of the Medical Officers :-
   (*c*) Name 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 :

5. Place of permanent employment of the specialist Medical Officer/others :
   (*a*) Government :-
   (b) Other (Specify) :-
   (If it is government, the name and address of the hospital or medical institution and the post held by the officer currently)

6. Type of Practice :

Group	
Individual	
Other	

7. Hours of Practice :
8. Method of record keeping : Computer based record systems ☐
   Manual record keeping ☐
   Others ☐
9. Facilities for specialists consultation :
10. Availability of Medical Lab :
11. Dispensary :
12. Radiology Services :
13. If so, the number of the licence issued by the Atomic Energy Authority :-
14. Any other facilities (specify) :
15. Ownership of premises :
16. Practicing as a –
    General Practitioner : ☐ Specialist : ☐
    If so, what is your speciality ?
17. Method of Clinical waste disposal :
18. Method of sterilization of instruments and dressings :
19. Availability of an appointment system ? : Yes ☐ No ☐
20. If the application is for renewal whether a copy of the existing registration is attached :-
21. The number of the existing certificate of registrtion :-
22. The period of the validity of certificate : Up to
23. 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 :-

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,.

Seal

Signature *Date*

The relevant Provincial Director of Health Services.

Annexure IV

Ministry of Healthcare and Nutrition

Registration Form for Part Time Private General Practices / Dispensaries / Medical Clinics

Registration No. : [ ]
Official use only

GENERAL INFORMATION

1. Name of the person operating/maintaining the institution :-
2. (*a*) Address (Official) :-
   (*b*) Telephone No. :-
   (*c*) The relationship with the institution :-
3. (*a*) Name of the medical instution :-
   (*b*) Address :-
   (*c*) Telephone No. (Official) :-
   (*d*) E-mal :-
   (*e*) Web Site :-
4. Location of the institution :-
   District [ ] Province [ ]
5. The details of the medical staff including Doctors, Consultants engaged in the medical profession under this institution to be provided as an annexure :-
   (1) Name of the Medical Officer/specialist as at the date of application :-
   (2) Name of the Medical College in which the degree was obtained :-
   (3) Country :-
   (4) Names of the other personnel and the category :-
   (5) Place of permanent employment of the specialist/Medical Officer/Others :-
      (a) Government :
      (b) Other (Specify) :

   (If it is government the name and address of the hospital / medical institution and the post held by the officer currently)
6. (*a*) Basic degree :-
   (*b*) The Name of the Medical College in which the degree was obtained :-
7. Post graduate qualifications with date and the name of the degree awarding institutions :-
8. SLMC Registration Number and Date :-

9. Type of Practice :

Group	
Individual	
Other	

10. Hours of Practice :
11. Method of record keeping : Computer based record systems ☐
Manual record keeping ☐
Others ☐
12. Facilities for specialists' consultation :
13. Availability of Medical Lab :
14. Dispensary :
15. Whether Radiology Services available :
16. If so the number of the license issued by the Atomic Energy Authority :-
17. Any other facilities (specify) :- Available/Offered
18. Ownership of premises :
19. Practicing as a –
General Practitioner : ☐ or Specialist : ☐
If so, what is your speciality ?
20. Method of Clinical waste disposal –
21. Method of sterilization of instruments and dressings –
22. Availability of an appointment system ? Yes ☐ No ☐
23. If the application is for renewal whether a copy of the existing registration is attached :-
24. The number of the existing certificate of registration :-_____
25. The period of the validity of certificate : Up to
26. Whether fee is paid, if so the 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 :- *Date* ……

Name :-
Designation :-

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,

Seal

Signature *Date*
The relevant Provincial Director of Health Services.

Annexure V

Ministry of Healthcare and Nutrition

Private Medical Institution Registration Form

REGISTRATION FORM FOR FULL TIME PRIVATE DENTAL SURGERIES

Registration No. : [ ]
To be specified by the Ministry

GENERAL INFORMATION

1. (*a*) Name of the person who is operating or maintaining the institution :-
   (*b*) The relationship with the institution :-
   (*c*) Address :-

2. (*a*) Name of the institution :-
   (*b*) Address :-

3. Location of the Institution :-
   District [ ] Province [ ]

4. Details of the Medical Officers and other staff attached to the institution as at the date of application :-
   (*a*) Name of the Dental Surgeon/Others :-
   (*b*) Address :-

Private	
Work Place	
Private Practice (I)	
Private Practice (II)	

If there are more than one Medical Officer engaged in the medical profession the details of such medical staff and others be submitted as a separate annexure along with this application.

(*c*) Communication :

General Tel. No. :	
Fax No. :	
Mobile No. :	
E-mail No. :	

(*d*). SLMC Registration No. :

(*e*)

Qualifications	*Basic*	*Post Graduation*	*Year*	*University*	*Country*

(*f*) Government Officer or not (if yes name of the institution and the post held by the officer currently) –

(*g*) Type of Practice :

Full time	
Group	
Individual	
Private Hospital / Nursing Home	
Private Dental Practitioner :	

(*h*) Hours of Practice :

5. Method of record keeping : Computer based record systems [ ]
   Manual record keeping [ ]
6. Availability of visiting specialists :
7. Dental Laboratory facilities :
8. X - ray facilities :-
   (a) The Number of license issued by the Atomic Energy Authority :-
9. Emergency Kit available or not :-
10. Any other facilities (specify) :- available/offered
11. Ownership :

    Own Practice : [ ] Locum : [ ]

12. Practicing as a –
    General Practitioner : [ ] Specialist : [ ]
    If so, what is your speciality ?
13. Clinical waste disposal method :-

14. Method of sterilization of instruments and dressings :

15. Availability of an appointment system ? Yes ☐ No ☐

16. Equipment and Facilities (Annex a list) :- available to provide service

17. If the application is for renewal whether a copy of the existing registration is attached :- Yes ☐ No ☐

18. The number of the existing certificate of registration :- _____

19. The period of the validity of the certificate : Up to

20. Whether fee is paid, if so the 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",
385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10, Sri Lanka. Tel. 0112674680.

The above application is forwarded herewith.

Seal

....

Signature, *Date.*

The relevant Provincial Director of Health Services.

Annexure VI

Ministry of Healthcare and Nutrition

Private Medical Institution Registration Form

REGISTRATION FORM FOR PART TIME PRIVATE DENTAL SURGERIES

Registration No. : [ ]

To be specified by the Ministry

GENERAL INFORMATION

1. Name of the person operating or maintaining the institution –
2.
   (*a*) Address :
   (*b*) Telephone No. : (i) Official [ ]
   (ii) Private [ ]
3. Name of the Institution :
4. (*a*) Address :
   (*b*) Telephone No. :
5. Location :
   District [ ] Province [ ]
6. Details of the Medical Officers and others attached to the institution as at the date of application :
   (*a*) Name :
   (*b*) Address :

Private	
Work Place	
Private Practice (I)	
Private Practice (II)	

If there is more than one Medical Officer engaged in the medical profession the details of such medical staff and others be submitted as a separate annexure along with this application.

(*c*) Communication :

General Tel No. :	
Fax No. :	
Mobile No. :	
E-mail No. :	

(*d*) SLMC Registration No. :

(*e*)

Qualifications	*Basic*	*Post Graduation*	*Year*	*University*	*Country*

(*f*) Government officer or not (If yes name of the institution and the post held by the officer currently) :

(*g*) Type of practice :

Part time	
Group	
Individual	
Private Hospital/Nursing Home	
Private Dental Practioner	

(*h*) Hours of practice :

7. Method of record keeping : Computer based record systems ☐
Manual record keeping ☐

8. Availability of visiting specialists :

9. Dental Laboratory facilities :

10. X - ray facilities :

(*a*) The number of licence issued by the Atomic Energy Authority

11. Emergency kit available or not :

12. Any other facilities (specify) : available/offered

13. Ownership :

Own Practice : ☐ Locum : ☐

14. Practising as a –

General Practitioner : ☐ Specialist : ☐

If so, what is your speciality ? :

15. Clinical waste disposal method :

16. Method of sterilization of instruments and dressings :

19. Availability of an appointment system ? Yes ☐ No ☐

18. Equipment and Facilities (annex a list) available to provide services :

19. If the application is for renewal, whether a copy of the existing registration is attached :

20. The number of the existing certificate of registration : _____

21. The period of the validity of the certificate | Up to |

22. Whether fee is paid, if so the copy of the 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.
Telephone No. : 0112674680

The above application is forwarded herewith,

Seal

…… ……
Signature, Date.
The relevant Provincial Director of Health Services.

Annexure VII

Ministry of Healthcare and Nutrition

Private Medical Institution Registration Form

REGISTRATION FORM FOR FULL TIME MEDICAL SEPECIALIST PRACTICES

Registration No. : [ ]

To be specified by the Ministry

GENERAL INFORMATION

1. Name of the the institution :
2. Address :

3. (*a*) Name of the person operating/maintaining the institution :
   (*b*) The relationship with the instittion :

	Address
Official	
Residence	
Private Practice	

4. Communication :

	Official	*Residence*
Tel. No.		
Fax No.		
Mobile No.		
E--mail No.		

5. The details of the medical staff including Doctors, Consultants enaged in the medical profession under this institution to be provided as an annexure –

   (*a*) Names of the Medical specialists as the 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 (speciafy) :

(*e*) Whether full time or part time :

(*f*) Post graduate qualifications and date and the name of degree awarded institute :

(*g*) SLMC registration No. and date :

6.

Qualifications	*Basic*	*Post Graduation*	*Year*	*University*	*Country*

7. Type of practice :

Full time	
Group	
Individual	
Private Hospital/Nursing Home	
Private Dental Practitioner	

8. Hours of practice –

9. Location of practice –

District : Province :

10. Speciality of practice :

11. Method of record keeping : Computer based record systems / Manual record Keeping

12. Emergency kit available or not –

13. Any other facilities (specify) : available/offered

14. Ownership :

Own practice : Locum :

15. Clinical waste disposal method :

16. Method of sterlization of instruments and dressings :

17. Availability of an appointment system : Yes No

18. Equipment and Facilities (annex a list) available to provide services :

19. If the application is for renewal whether a copy of the existing registration is attached :

20. The number of the existing certificate of registration :

21. The period of the validity of certificate | Up to |

22. Whether fee is paid, if so the copy of receipt is attached

Yes	
No	

I certify that the above information is ture 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 Healtcare and Nutrition,
"Suwasiripaya",
No. 385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10,
Sri Lanka.
Tel. No. : 011-2674680

The above application is forwarded herewith.

……

Signature,
The relevant Provincial Director of
Health Services.

Seal

Date.

Annexure VIII

Ministry of Healthcare and Nutrition

Private Medical Institution Registration Form

REGISTRATION FORM FOR PART TIME MEDICAL SEPECIALIST PRACTICES

Registration No. : [ ]
To be specified by the Ministry

GENERAL INFORMATION

1. Name of the the institution :
2. Address :
3. (*a*) Name of the person operating/maintaining the institution :
   (*b*) The relationship with the institution :

	Address
Official	
Residence	
Private practice	

4. Communication :

	Official	*Residence*
Tel. No.		
Fax No.		
Mobile No.		
E--mail No.		

5. The details of the medical staff including Doctors, Consultants enaged in the medical profession under this institution to be provided as an annexure –
   (*a*) Names of the Medical specialists as at the date of application :
   (*b*) Name 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 (speciafy) :
   (*e*) Whether full time or part time :
   (*f*) SLMC registration No. and date :

6.

Qualifications	*Basic*	*Post Graduation*	*Year*	*University*	*Country*

7. Type of practice –

Part time	
Group	
Individual	
Private hospital/Nursing home	
Private Dental Practitioner	

8. Government Officer or not (If yes name of the institution and the post held currently) :
9. Hours of practice : –
10. Location of Institution :

District [ ] Province [ ]

11. Speciality of practice –
12. Method of record keeping Computer based record systems [ ] Manual record keeping [ ]
13. Emergency kit available or not :
14. Any other facilitie s(specify) : available/offered
15. Ownership :
    Own practice : [ ] Locum : [ ]
16. Clinical waste disposal method :
17. Method of sterilizaiton of instruments and dressings :
18. Availability of an appointment system : Yes [ ] No [ ]
19. Equipment and Facilities (annex a list) available to provide services –
20. If the application is for renewal whether a copy of the existing registration is attached :
21. The number of the existing certificate of registration : _____
22. The period of the validity of certificate Up to
23. Whether fee is paid, if so the 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,

Secretaty,
Private Health Service Regulatory Council,
Ministry of Healthcare and Nutrition,
"Suwasiripaya",
No. 385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10,
Sri Lanka.
Tel. No. : 011-2674680

The above application is forwarded herewith,

Seal

…… ……

Signature, Date.
The relevant Provincial Director of Health Services.

Annexure IX

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. (*a*) Name of the person who is operating or maintaining the institution :-
   (*b*) (i) Address (Official) :
   (ii) 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 ☐
   - (v) 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 –

(*a*) 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 and 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			
MRI Scanners		Others (please specify)	
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 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 : Date……

Name :

Designation :

Return after completion through the relevant Provincial Director of Health Service to,

Secretary,
Private Health Services Regulatory Council,
Ministry of Healthcare and Nutrition,
"Suwasiripaya",
No. 385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10.
Sri Lanka.
Telephone No. : 0112674680.

The above application is forwarded herewith.

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Signature, Seal Date
The relevant Provincial Director of
Health Services.

Annexure X

MINISTRY OF HEALTHCARE AND NUTRITION

Registration Form for Other Private Medical Institutions

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. (*a*) Name of the person who is operating or maintaining the institution : ————.
   (*b*) (i) Address:
   (ii) Telephone No. : (Official) : ————.
   (Private) : ————.
   (*c*) The Relationship with the institution : ————.

6. Type of the Institution - *(Tick on appropriate cage)*

(*a*) Home Care Nursing Services	
(*b*) Blood Bank	
(*c*) E - medical systems	
(*d*) Other	

7. Ownership status — (Tick on appropriate cage)

(*a*) Public Company	
(*b*) Private Company	
(*c*) Other	

8. 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) :-

If there is more than one person working in the institution such details should be submitted as an annexure along with this application :

9. Date of Establishment :

10. Company/Business Registration No. :

11. BOI Registration : (if any)

12. Human Resources :

(i) 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 :		

(ii) Other Technical Staff and their registrations :

(iii) Brief description of services :

13. Units and 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			
MRI Scannes		Others (please specify)	
CT Scanners			

If more than 01 unit please indicate the number

14. If Radiology and X-Ray facilities are available, 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 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 :

Return after completion through the relevant Provincial Director of Health Service to,

Secretary,
Private Health Services Regulatory Council,
Ministry of Healthcare and Nutrition, "Suwasiripaya",
No. 385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10.
Sri Lanka.
Telephone No. : 0112674680.

The above application is forwarded herewith

....

Signature
The relevant Provincial Director of
Health Services.

Seal

Date

Annexure XI

MINISTRY OF HEALTHCARE AND NUTRITION

Registration form for Private Ambulance Services

Registration No. [ ]

Official use only

General Information

1. Name of the Ambulance Services :-

2. Address :-

3. General Tel. No :-
   Fax No. :
   E-mail address :
   Web site address (If available) :

4. (*a*) Name of the person operating / maintaining the ambulance service :-
   (*b*) Address:
   (*c*) Telephone No. : (Office) :
   (Private) :

5. Whether a public company or not - | Yes | No |

6. Details of the Ambulances -
   (i) No. of Ambulances :-
   (ii) Model :-
   (iii) Facilities available :-
   (iv) Equipment :-
   (v) Health staff to accompany patients :-
   (vi) Extracts of the RMV Registration :-
   (vii) Names of the Drivers :-
   (viii) Copies of the driving License :-

7. (i) Administration staff :

Designation	*Name*	*Mobile/Contact Tel. No.*
Chairman	.....	
CEO/Managing Director	.....	
Administrative Officer	.....	
Accountant	.....	
Other Major Staff	.....	

(ii) Staff members :-

(*a*) Names of the Doctors and qualifications and SLMC registration Numbers :-
(*b*) Names of the Nurses and qualifications and SLMC registration Numbers :-
(*c*) Whether employed in government, If so the post hold currently and the place of work :

8. Facilities and machinery available - (attach as an annex)

9. Total investment :-

10. Location of the institution :-

Province	
District	

11. If the application is for renewal whether a copy of the existing registration is attached :

12. The number of the existing certificate of registration :

13. The period of the validity of certificate

Up to

14. 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 :

Return after completion through the relevant Provincial Director of Health Service to,

Secretary,
Private Health Services Regulatory Council,
Ministry of Healthcare and Nutrition, "Suwasiripaya",
No. 385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10.
Sri Lanka.
Telephone No. : 0112674680.

The above application is forwarded herewith

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Signature Seal Date

The relevant Provincial Director of
Health Service.

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