BALOCHISTAN HEALTHCARE COMMISSION

House # 15, 2nd Lane, Phase-III, Shahbaz Town, Quetta.
bhcc.qta@gmail.com 081-2081375/2084799

Form Fee: Rs. 200/-

APPLICATION FOR REGISTRATION

(Please Read and fill the form carefully. Cutting is not allowed).

APPLICATION FOR REGISTRATION WITH BALOCHISTAN HEALTHCARE COMMISSION	**For office use**: application number: _____

IMPORTANT: Please follow the instructions completely. Failure to submit the necessary items/information will delay the processing of your application and may end up with the rejection.

Please tick the relevant box: and Identify fee paid *(The required fees must accompany the application)*

☐ With Indoor Facility (with hospital beds)	☐ Complete all sections
☐ Without Indoor Facility (All kind of clinics)	☐ Complete all sections except section 9
☐ Change of Ownership	☐ Complete sections 1, 2, 3 and 4
☐ Change of location	☐ Complete sections 1,2 and 7
☐ Change of HCE Name	☐ Complete sections 1, 2
☐ Change of Healthcare Service Provider	☐ Complete sections 1,2, 4 and 6
☐ Temporary Closure	☐ Complete section 1,2 and 5

1. MS/ Administrator/ Incharge of HCE/ Director Details (Must be registered with relevant council)	
Name (as it appears in CNIC):	**Gender** (*Please tick*): ☐ Male ☐ Female
Previous name (if different from above):	**CNIC Number:**
Designation:	
Status: ☐ Owner ☐ Manager ☐ In-charge	
Qualification (Highest):	

Address: _____		
District: _____ **Tehsil:** _____ **Locality:** _____		
Building/ House No: _____ **Street:** _____		
Landline Number:	**Mobile No:**	
Email:		
Name of second in-charge (as it appears in CNIC)	**Gender** (*Please tick*): ☐ Male ☐ Female	
Previous name (if different from above):	**CNIC Number:**	
Designation:		
Valid Registration No. PMDC/ PNC/ NCH/ NCT, any other council	**Date of Expiry:**	
Address: _____		
District: _____ **Tehsil:** _____ **Locality:** _____		
Building/ House No: _____ **Street:** _____		
Landline Number:	**Mobile No:**	
Email:		

2. HEALTHCARE ESTABLISHMENT DETAILS (Hospital, All Clinics, Nursery, Imaging Centre, Lab, MCH Center, Homoeo, Tibbs, & others)			
Name of Healthcare Establishment: Name Change: (if applicable)	Date of establishment at present location: ___/___/_____		
Address: _____			
District: _____ **Tehsil**: _____ **Locality:** _____			
Building/House No:	**Street:**		
Is this a changed location: **Yes / No (circle)**	**If Yes, Previous location:**		
	District:	**Tehsil:**	**Locality:**
	Building/House No.	**Street:**	

Landline Number:	**Mobile No:**
Is the current HCE licensed: Yes / No (circle) if yes, Previous License No:	
☐ **Premises Leased/Rented**	☐ **Premises Owned**
Name of lessor / Owner of building: _____ **Address of lessor / Owner of building**: _____ **Contact # of lessor / Owner of building**: _____ ***Note:*** ***A copy of the lease/rent agreement must be attached to this application.***	
Working Hours/ Operational Hours of Healthcare Establishment:	

3. OFF SITE COLLECTION CENTERS (CC)		
☐ Yes	☐ No **(if yes then complete lower part of this section. If needed use the additional sheet)**	
Name of offsite CC	**Complete Address**	**Contact No.**
1.		
2.		
3.		
4.		
5.		
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16		

4. TYPE OF OWNERSHIP (please check the appropriate box)		
Government	**Others**	
☐ District Government	☐ Sole Proprietary	☐ Voluntary Non-Profit
☐ Provincial Government	☐ Partnership	☐ Association
☐ Federal Government	☐ Corporation	☐ Limited Liability Company (Pvt)
☐ Autonomous Institution	☐ Trust	☐ Limited Liability Company (Pub))
Owners Name:	**CNIC #:**	**Contact No.**
Complete address of the owner of building:		
Is this a changed Owner: **Yes / No (circle)**	If Yes, Previous Owner name: District: _____ Tehsil: _____ Locality: _____ Building/House No. _____ Street: _____ Contact No. _____	
Signatures of current owner		**Signatures of previous owner**

5. TYPE OF HEALTHCARE ESTABLISHMENT (please check the relevant box)		
A. By System of Treatment		
a) Allopathic ☐	b) Homeopathic ☐	c) Tibb ☐
B. By Availability of indoor beds		
With Indoor beds ☐	Without indoor beds ☐	
C. By Teaching Status		
a) Teaching ☐	b) Non-Teaching ☐	
D. Specific Type		
Aesthetic Clinic ☐	Family Planning Clinic ☐	Poly Clinic ☐
Addiction Treatment Centre ☐	General Medical Practitioner Clinic/ Dispensary ☐	Single Specialty Clinic ☐
Advanced Diagnostic Centre ☐	Hair Transplant Clinic ☐	Tibb Clinic ☐
Advanced Imaging Centre ☐	Homoeopathic Clinic ☐	Home Healthcare Service ☐

Clinical Laboratory ☐	Hospital ☐	Convalescence Home ☐
Collection & Imaging Centre ☐	Mobile Clinics ☐	Blood Bank ☐
Collection Centre ☐	Maternity Home ☐	Patient Transfer Services ☐
Cosmetic Surgery Clinic ☐	Mobile Vaccination Van ☐	Tele-health Centre ☐
Dental Clinic ☐	Nursing Home ☐	Dialysis Centre ☐
Diagnostic Centre ☐	Other Specify ☐	

6. STAFFING SUMMARY (Full- Time Staff)

Indicate number of **full time (FT)** staff (Attach additional pages if needed).
By name list to be enclosed as per Appendix-1

Sr. #	Category	No of Full-Time staff
1	Healthcare Management Personal/ Supervisor/ Incharge section	
2	Consultants	
3	Medical Officers	
4	PG Trainees	
5	House Officers	
6	Nurses	
7	Pharmacist	
8	Allied Health Professionals / Paramedic Staff	
9	Support staff	
10	Others (specify)	
	Total	

6-A. STAFFING SUMMARY (Part- Time Staff)		
Indicate number of **full time (PT)** staff (Attach additional pages if needed). ***By name list to be enclosed as per Appendix-1A***		
Sr. #	**Category**	**No of Part-Time staff**
1	Healthcare Management Personal/ Supervisor/ Incharge of section	
2	Consultants	
3	Medical Officers	
4	PG Trainees	
5	House Officers	
6	Nurses	
7	Pharmacist	
8	Allied Health Professionals / Paramedic Staff	
9	Support staff	
10	Others (specify)	
	Total	

7. BUILDING PLANS (Map/ Cite plan)			
Do you have building plans?	Yes & approved ☐ Yes, but not approved ☐		No ☐
Are building alteration and remodeling proposed in the next 5 years?		Yes ☐	No ☐
No. of floors: ( )	Residential accommodation	Yes ☐	No ☐
No. of Generator: ( )	Parking	Yes ☐	No ☐
Fire Exit	Yes ☐ No ☐	No. of chillers / A.C:	

Offsite locations will include any type of collection centers, laboratories, branch sites etc. Please provide information in terms of sq. ft.

8. SERVICES PROVIDED BY THE HEALTHCARE ESTABLISHMENT (HCE)			
Sr. #	**Services**	**Sr. #**	**Services**
1.	Medicine	18.	Orthopedics
2.	Neonatology	19.	Trauma Management
3.	Neurology	20.	ENT
4.	Oncology	21.	Eye
5.	Rheumatology	22.	Gynae & Obs
6.	Pulmonology	23.	Pediatric Surgery
7.	CCU	24.	Cardiac Surgery
8.	Emergency	25.	ICU
9.	Blood Bank	26.	Neurosurgery
10.	Laboratory	27.	Facio-maxillary
11.	Radiology & diagnostic Imaging	28.	Urology
12.	Pharmacy Indoor	29.	Plastic Surgery
13.	Pharmacy Outdoor	30.	Dentistry
14.	Physiotherapy	31.	Homeopathy
15.	Speech Therapy	32.	Tibb
16.	Nutrition	33.	Gastroenterology
17.	General Surgery		
Other Services (if any, please mention)			

8-A. DIAGNOSTIC SERVICES PROVIDED BY THE HEALTHCARE ESTABLISHMENT (HEC)			
Sr. #	**Services**	**Sr. #**	**Services**
1.	Endoscopic procedures	**7.**	CT scan
2.	PET scan	**8.**	MRI
3.	Electroencephalogram (EEG)	**9.**	Ultra Sound
4.	Laboratory	**10.**	ECHO
5.	X-Ray	**11.**	ECG
6.	Angiography	**12.**	Thallium Scan
Other Diagnostic Services (if any, please mention)			

8-B. Scope of Services of Healthcare Establishment (HCE) for OUTDOOR Only			
Sr. #	**Scope of Services/ Services offered**	**Sr. #**	**Scope of Services/ Services offered**
1.		**12.**	
2.		**13.**	
3.		**14.**	
4.		**15.**	
5.		**16.**	
6.		**17.**	
7.		**18.**	
8.		**19.**	
9.		**20.**	
10.		**21.**	
11.		**22.**	
Other Services (if any, please mention)			

9. BED CAPACITY				
		Total beds	**Male**	**Female**
1.	Medical and allied			
2.	Surgical and allied			
3.	ICU			
4.	CCU			
5.	ICU Neonates			
6.	Emergency			
7.	Dental Clinic (No. of Seats)			
8.	Others			
Total				

10. EXTERNAL VALIDATION

List all applicable external certificate, licenses, accreditation and similar Awards/ Certificates

Agency_____ Award _____

Agency_____ Award _____

Agency_____ Award _____

Agency_____ Award _____

Agency_____ Award _____

11. DECLARATION

I/we, the undersigned, do hereby solemnly affirm and declares that the information provided about HCE are true and correct to the best of my/our knowledge and belief and that nothing has been concealed there from. I/we understand that if any false or incorrect information is provided to the Commission, it may result in rejection of my application for Registration, and I may also be found liable to pay fine to the Commission. I further undertake to inform the Commission in writing, within fifteen days of any addition/alteration made in the services/premises, at any time in future.

Name of Healthcare Service Provider:	**Signatures:** **Date**
Name of the Owner*:	**Signatures:** **Date**

***Only if the services provider is different from the owner**

12. CHECKLIST

Please use the checklist to make sure that you have attached all necessary documents.

- ☐ Architectural Drawings / Map.
- ☐ Copy of lease/rent agreement (in case of rented building) with the owner of the real estate on which the facility is built or proof of ownership if building owned.
- ☐ Copy of previous license (if applicable).
- ☐ Copy of all approvals obtained from required departments and organizations in the Balochistan Province e.g., Civil defense, fire safety, Local government.
- ☐ Receipt payment challan of applicable fees.
- ☐ Other:

Appendix-1

Staffing (Full-Time)

A. Healthcare Management Personnel/ Incharge of Sections and services					
Sr. #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

(If needed attached extra sheet)

B. Consultants					
Sr. #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					

(If needed attached extra sheet)

C. Medical Officers (MBBS Doctors)					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
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10					

(If needed attached extra sheet)

D. PG Trainees					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
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10					

(If needed attached extra sheet)

E. House officers					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
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7					
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10					

(If needed attached extra sheet)

F. Nurses					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

(If needed attached extra sheet)

G. Pharmacists					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

(If needed attached extra sheet)

H. Allied Health Professionals / Paramedic staff					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

(If needed attached extra sheet)

I. Support staff					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
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21					
22					
23					

(If needed attached extra sheet)

J. Others					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
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3					
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25					
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27					

Appendix-1A

Staffing (Part-Time)

A. Healthcare Management Personnel/ Incharge of Sections and services					
Sr. #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

(If needed attached extra sheet)

B. Consultants					
Sr. #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					

(If needed attached extra sheet)

C. Medical Officers (MBBS Doctors)					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
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7					
8					
9					
10					

(If needed attached extra sheet)

D. PG Trainees					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
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9					
10					

(If needed attached extra sheet)

E. House officers					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

(If needed attached extra sheet)

F. Nurses					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

(If needed attached extra sheet)

G. Pharmacists					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

(If needed attached extra sheet)

H. Allied Health Professionals / Paramedic staff					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
2					
3					
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7					
8					
9					
10					

(If needed attached extra sheet)

I. Support staff					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
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23					

(If needed attached extra sheet)

J. Others					
S #	**Name**	**Designation**	**Duty Timings**	**Council Rgd. # (If applicable)**	**Contact #**
1					
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Appendix-2

List of Electro - Medical Equipment

Sr. #	Name	Make	Model
1			
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21			

(If needed attached extra sheet)

Appendix-3

List of Machinery

Sr. #	Name	Make	Model
1			
2			
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8			
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10			
11			
12			
14			

(If needed attached extra sheet)

Appendix-4

Colour of dress code according to post/ designation of Health Staff		
Sr#	**Designation**	**Colour of dress Code**
1	Doctors	
2	Nurse	
3	LHV/LHW	
4	Para Medics	
5	Specify any other	

For more details and updates, (Follow BHCC Official Facebook Page):

1. ***Balochistan Healthcare Commission (BHCC)***
   https://www.facebook.com/profile.php?id=61571972083218