



DOH-HFSRB-QOP-01-Form1

Form 1- Revised

Name of Health Facility (HF) or Service Provider : _____

HF Complete Address : _____
 No. & Street Barangay District

City/Municipality Province Region

Telephone Number: _____ E-mail Address : _____ Official Mobile No. _____

Head of the Facility/Medical Director : _____

Owner : _____

Classification According to:

- Ownership: [] Government [] Province [] City [] Mun. [] DOH-Retained [] School Others Specify _____
 [] Private [] Corporation [] Partnership [] Single Proprietorship [] Cooperative Others Specify _____
 Institutional Character: [] Institution-based [] Non Institution-based [] Free-Standing

Status of Application: [] New [] Renewal
 License No. _____ Validity _____

Permit to Construct No. (If applicable) _____ Date Issued _____ Authorized Bed Capacity (ABC) : _____

Instruction: Please tick (✓) the appropriate boxes below and provide necessary documents.

LICENSE TO OPERATE:

- [] Ambulatory Surgical Clinic
 Service/s: [] colorectal surgery [] otolaryngologic surgery
 [] general surgery [] pediatric surgery
 [] ophthalmologic surgery [] plastic and reconstructive surgery
 [] oral and maxillo-facial surgery [] reproductive health surgery
 [] orthopedic surgery [] thoracic surgery
 [] urologic surgery

- [] Birthing Home
 [] Blood Service Facility: [] Blood Station (Hosp-based) [] Blood Bank [] Blood Bank w/ Addtl. Function [] Blood Center

- [] Clinical Laboratory
 [] Dental Laboratory
 [] Dialysis Clinic
 [] HIV Testing Laboratory
 [] Hospital

Function: [] General [] Level 1 [] Level 2 [] Level 3

[] Specialty, Specify _____

- [] Infirmary
 [] Primary Care Facility
 [] Psychiatric Care Facility [] Acute Chronic [] Custodial
 [] Ambulance Service Provider No. of Ambulance Unit: Type I _____ Type II _____

CERTIFICATE OF ACCREDITATION

- [] Drug Abuse Treatment and Rehabilitation Center [] Residential [] Residential w/OutPt [] Non-Residential
 [] Human Stem Cell and Cell-Based or Cellular Therapy Facility
 [] Kidney Transplant Unit
 [] Laboratory for Drinking Water Analysis [] Bacteriological [] Chemical [] Physical
 [] Laboratory for Chemical Water Analysis for Dialysis Clinic
 [] Medical Facility for Overseas Work Applicants [] Regular Medical Facility
 [] Special Seafarer's Med. Fac. [] Special Land-based Med. Fac.

- [] Newborn Screening Center

CERTIFICATE OF REGISTRATION:

- [] Special Clinical Laboratory Service Capability, Specify _____

AUTHORITY TO OPERATE (For Free Standing)

- [] Blood Collection Unit [] Blood Station

Documents	New	Renewal
1. Acknowledgement (notarized)		
2. Proof of Ownership and Name of Health Facility: 2.1 DTI/SEC/CDA Registration including Articles of Incorporation/Cooperation and By-Laws 2.2 Enabling Act/ LGU Resolution (for government health facility)		XXXXXXXX
3. Application Form for Medical X-ray Facility (if applicable)		
4. Application Form for Pharmacy (if applicable)		
5. Accomplished Health Facility Self-Assessment Tool		
6. Health Facility Geographic Form (Geographic Coordinates)		XXXXXXXX

Note: Please refer to www.hfsrb.doh.gov.ph for other details of the requirements.

Name and Signature of Applicant
 (Owner/President of the Company/
 Head of the Facility)

Date of Application

Acknowledgement

REPUBLIC OF THE PHILIPPINES) CITY/
MUNICIPALITY OF _____) S.S.

I, _____, _____, of legal age, _____, a resident of
Name Civil Status Age

_____, after having been sworn in accordance with law
Address

hereby depose and say that I am executing this affidavit to attest to the completeness and truth of the foregoing information and the attached documents required for the establishment/operation of health facility pursuant to existing rules and regulations. That the undersigned is aware and informed that any misrepresentation, falsification/deception herein can cause the denial of my application, suspension or revocation of my license/ accreditation.

Signature

Before me, this _____ day of _____ 20____ in the City/Municipality of _____, Philippines, personally appeared the above affiant with Community Tax Certificate No. _____ issued on _____ at _____, Known to me to be the same person/s who executed the foregoing instrument and they acknowledge to me that the same is their free act and deed.

Owner Community Tax Number Issued at/ on

known to me to be the same person/s who executed the foregoing instrument and they acknowledge to me that the same is their free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hands this _____ day of _____, 20____

Doc No. _____
Page No. _____
Book No. _____
Series of _____

NOTARY PUBLIC
My Commission Expires
Dec. 31, 20 ____