DOH-HFSRB-QOP-01-Form 2

Form 2 -Revised

Name of Health Facility (HF)/Service Provider _____

HF Complete Address: _____

No. & Street Barangay District

_____

City/Municipality Province Region

Telephone No. _____ E-Mail Address _____ 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

Latest LTO/COA/ATO No. _____ Validity Period from _____ to _____

Permit to Construct No. (if applicable) _____ Date Issued: _____

Type of Health Facility/Service:

License to Operate:

[ ] Ambulatory Surgical Clinic [ ] Ambulance Service Provider

[ ] Birthing Home Ambulance unit/s approved: No. _____ Type _____

[ ] Blood Service Facility: ☐ Blood Station (Hosp-based) ☐ Blood Bank ☐ Blood Bank w/ Addt'l. Function ☐ Blood Center

[ ] Clinical Laboratory

[ ] Dental Laboratory

[ ] Dialysis Clinic

[ ] HIV Testing Laboratory

[ ] Hospital [ ] General ☐ Level 1 ☐ Level 2 ☐ Level 3

[ ] Specialty, Specify _____

[ ] Infirmary

[ ] *Primary Care Facility*

[ ] Psychiatric Care Facility

Certificate of Accreditation:

[ ] Drug Abuse Treatment and Rehabilitation Center [ ] *Laboratory for Chemical Water Analysis for Dialysis Clinic*

[ ] Human Stem Cell & Cell-Based or Cellular Therapy [ ] Medical Facility for Overseas Workers and Seafarers

[ ] Kidney Transplant Facility [ ] Newborn Screening Center

[ ] Laboratory for Drinking Water Analysis

CERTIFICATE OF REGISTRATION:

[ ] Special Clinical Laboratory Service Capability, Specify _____

AUTHORITY TO OPERATE (For Free Standing)

[ ] Blood Collection Unit [ ] Blood Station

Type of Application for Change/s (in existing HF) **[Please check [√] appropriate box].**

☐ Increase/Decrease in ABC from _____ to _____

☐ Increase/Decrease in no. of dialysis station from _____ to _____

☐ Change/Additional Equipment (including devices under FDA) Specify _____

☐ Change/Additional personnel Specify _____

☐ Change in service/s Specify _____

☐ Additional service/s Specify _____

☐ Change in classification (function, institutional character) Specify _____

☐ Increase/Decrease in ambulance vehicle: No. of Unit/s from _____ to _____ Type (Specify) from _____ to _____

☐ Hospital downgrading from _____ to _____

☐ Change in Name to _____

☐ Others Specify _____

Note: Please attach documentary requirements with change/s

Details of Change/s _____

_____

_____ _____

Signature over printed name of Head of the Facility/Owner Date

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Recommendation: Date_____

☐ For inspection ☐ Others Specify _____

☐ For submission of documents _____

☐ For issuance of LTO/COA/COR/ATO

Recommended by: Approved by:

_____ _____

Print Name and Signature