Republic of the Philippines
Department of Health
HEALTH FACILITIES AND SERVICES REGULATORY BUREAU

APPLICATION FOR LICENSE TO OPERATE

Name of Health Facility or Service Provider : _____

Address : _____

No. & Street Barangay

_____

City/Municipality Province Region

Type of Health Facility or Service:

[ ] Ambulatory Surgical Clinic

Service/s:

- ☐ colorectal surgery
- ☐ general surgery
- ☐ ophthalmologic surgery
- ☐ oral and maxillo-facial surgery
- ☐ orthopedic surgery
- ☐ otolaryngologic surgery
- ☐ pediatric surgery
- ☐ plastic and reconstructive surgery
- ☐ reproductive health surgery
- ☐ thoracic surgery
- ☐ urologic surgery

[ ] Birthing Home
[ ] Blood Bank
[ ] Clinical Laboratory
[ ] Dental Laboratory
[ ] Dialysis Clinic
[ ] HIV Testing Laboratory
[ ] Hospital

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

[ ] Specialty, Specify _____

[ ] Infirmary
[ ] Psychiatric Care Facility

- ☐ acute chronic
- ☐ custodial

[ ] Ambulance Service Provider

Telephone No.: _____ Fax No : _____ E-mail Address: _____

Head of the Facility/Medical Director : _____

Owner : _____

Classification According to:

Ownership: [ ] Government [ ] Private

Institutional Character: [ ] Institution-based [ ] Non Institution-based

Status of Application: [ ] Initial [ ] Renewal

License No. _____

Validity _____

Authorized Bed Capacity (ABC) : _____

Please tick (✓) the appropriate boxes below and provide necessary documents. Item shaded is not required.

Documents	Initial	Renewal
1. Acknowledgement (notarized)		
2. List of Personnel (use ANNEX A)		
3. List of Equipment/Instrument (use ANNEX B)		
4. List of Ancillary Services (ANNEX C - for Hospital)		
5. Application Form (for Medical X-ray Facility)		
6. Application Form (for Hospital Pharmacy)		
7. Health Facility Geographic Form (Location Map)		XXXXXXXX
8. Photographs of the exterior and interior of the health facility		XXXXXXXX
9. Annual Statistical Report (where applicable)	XXXXXXXX	

Note: Please refer to *www.hfsrb.doh.gov.ph* **Application Form for other ancillary services**

_____ _____

Name and Signature of Applicant **Date of Application**

ANNEX A

LIST OF PERSONNEL

Name of Health Facility or Service Provider: _____

Address: _____

Fill up all items by writing down the answer and/or putting a check on the appropriate boxes.

Name	Designation/ Position	Highest Educational Attainment and Post Graduate Course (if applicable)	Specialty Board Certificate (for physicians), specify (where applicable)	P R C		STATUS			Signature
				Reg. No.	Validity Period	Permanent	Contractual	Others, specify*	

*(e.g. one peso consultant, visiting consultant, affiliates etc.)

Use additional sheets when necessary

Prepared by: _____

ANNEX B

LIST OF EQUIPMENT/INSTRUMENT

Name of Health Facility or Service Provider: _____

Address: _____

Brand Name & Model	Serial No.	Quantity	Date of Purchase

Use additional sheets when necessary.

Prepared by: _____

ANNEX C

LIST OF SERVICES IN A HOSPITAL

GENERAL	LEVEL 1	LEVEL 2	LEVEL 3
Clinical Services and Facilities for In-Patients	[ ] Consulting Specialists in: [ ] Medicine [ ] Pediatrics [ ] OB-GYNE [ ] *Surgery* [ ] Emergency and Out-patient Services [ ] *Isolation Facilities* [ ] *Surgical/Maternity Facilities* [ ] *Dental Clinic*	[ ] Consulting Specialists in: [ ] Medicine [ ] Pediatrics [ ] OB-GYNE [ ] Surgery [ ] Emergency and Out-patient Services [ ] Isolation Facilities [ ] Surgical/Maternity Facilities [ ] Dental Clinic [ ] Departmentalized Clinical Services [ ] *Respiratory Unit* [ ] General ICU [ ] *High Risk Pregnancy Unit* [ ] NICU	[ ] Consulting Specialists in: [ ] Medicine [ ] Pediatrics [ ] OB-GYNE [ ] Surgery [ ] Emergency and Out-patient Services [ ] Isolation Facilities [ ] Surgical/Maternity Services [ ] Dental Clinic [ ] Departmentalized Clinical Services [ ] Respiratory Unit [ ] General ICU [ ] High Risk Pregnancy Unit [ ] NICU [ ] Teaching/Training w/ Accredited Residency Training Program in: [ ] Medicine [ ] Pediatrics [ ] OB-GYNE [ ] Surgery [ ] Physical Medicine and Rehabilitation Unit [ ] *Ambulatory Surgical Clinic* [ ] *Dialysis Clinic*
Ancillary Services	[ ] *Secondary Clinical Laboratory* [ ] *Blood Station* [ ] *1st Level X-ray* [ ] *Pharmacy*	[ ] Tertiary Clinical Laboratory [ ] Blood Station [ ] *2nd Level X-ray w/ mobile unit* [ ] Pharmacy	[ ] Tertiary Laboratory *w/ histopathology* [ ] Blood Bank [ ] 3rd Level X-ray [ ] Pharmacy
Other Ancillary Services	**[ ] Specialized Diagnostic X-ray Services** [ ] Computed Tomography [ ] Lithotripsy [ ] Cardiac Catheterization [ ] Mammography [ ] Bone Densitometry [ ] Digital Subtraction Angiography [ ] Percutaneous Transluminal Angioplasty **[ ]** Tumor Localization and Simulation	**[ ] Radiation Oncology** [ ] Conventional Radiation Therapy [ ] Stereotactic Radiosurgery (SRS) [ ] Intensity Modulated Radiation Therapy (IMRT) [ ] 3D Conformal Radiation Therapy [ ] Total Body Irradiation (TBI)	[ ] HIV Testing Laboratory [ ] Laboratory for Drinking Water Analysis [ ] Drug Testing Laboratory [ ] others, specify

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 license to operate pursuant to existing rules and regulations.

_____
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 ____