6.	Type of practice: -
	Group
	Individual / Other
7.	
-	10400 PM + 100 00 00 PM
8.	Memory of record sections Computer based record systems
	Manual record keeping
	Others
9.	Facilities for specialists consultation:
10.	Availability of medical lab: -
11.	Dispensary: - YES
11.	Dispensity 7 4 3
12.	Radiology Services: -
13.	If so the number of the license issued by the Atomic Energy Authority -
14.	Any other facilities (specify): -
	memues (specify).
15.	Ownership of premises: - SELF
16.	Practicing as a,
	ractioning as a,
	General Practitioner: or Specialist:
	If so, what is your speciality?
17.	Method of Clinical waste disposal INCINERATOR
18.	
10.	Method of sterilization of instruments & dressings - ELECTRIE STERILIZE
19.	Availability of an appointment species
20.	ICS NO
	If the application is for renewal whether a copy of the existing registration is
	, , , ,
21. T	he number of the existing certificate of registration _ PHSRC FGP + ++
22. T	he period of the validity of certificate
	Whether fee is paid, if so the original copy of received
23. \	Whether fee is paid, if so the original copy of receipt is attached yes No No
I cer	rtify that the above information is true and correct. I further declare that the rtificate of registration can be cancelled or suspended at any stage my application
infor	mation furnished by me found to be incorrect. I feet and correct
or ce	mation furnished by me found to be incorrect or false at any stage my application ture of the person operating or maintains:
	add by a promoted
	TECHEN DR CHANDRON
Desig	PRACTITIONER Date: 10150
Priva	ge Health Services Regulatory Council. Date: 10/10 Date:



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 - S. POORANA CHANDRA

a. Address (Official) -) KUMARAKOTTAM,

b. Address (Private) - J ALADY; WALVETTITURAL

c. The relationship with the institution - DIRECTOR

2. Name of the medical institution: - WELWISH MEDICAL CENTRE

a. Address- as above

b. Telephone (Official) - 021 - 226 - 5152

c. E-mail -

d. Web site -

Location of the institut

Tocadon of the monther		
Province	NORTH	
District	TAFFNA	

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: NIL

c) Names of the other personnel and the category: NIL

d) Place of permanent employment of the specialist Medical Officer/ others:

a. Government b. Other (Specify)

0800-12:00 HRS e) Whether full time or part time: FLILL TIME 1600 - 2000 HRS, f) The name of the medical college in which the degree was obtained:

g) Country: SRI LANKA

h) Basic degree: REGID. MEDICAL PRACTITIONER

i) Post Graduate qualifications and date and the name of degree awarded institute:

SLMC Registration no and Date: 1090 Dated 09/02/2019 Place of permanent employment of the specialist Medical Officer/ others:

b. Other (Specify):

If it is government the name and address of the hospital/ medical institution and the post held by the officer currently: