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 CHANDRAN
   a. Address (Official) – } KUMARAKOTTAM,
   b. Address (Private) – } ALADY, VALVETTITURAI
   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 –

3. Location of the institution –

Province	NORTH
District	JAFFNA

4. 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: NIL
   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)
   e) Whether full time or part time: FULL TIME (0800 – 12:00 HRS, 1600 – 2000 HRS
   f) The name of the medical college in which the degree was obtained:
   g) Country: SRI LANKA
   h) Basic degree: REGD. MEDICAL PRACTITIONER
   i) Post Graduate qualifications and date and the name of degree awarded institute:
   j) SLMC Registration no and Date: 1090 Dated 09/02/201 (copy annexed)

5. Place of permanent employment of the specialist Medical Officer/ others:
   a. Government: ——
   b. Other (Specify):

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

6. Type of practice :-

Group	
Individual	✓
Other	

7. Hours of practice :- 08.00 AM till 12.00 Noon
04.00 PM till 08.00 PM

8. Method of record keeping :- Computer based record system
Manual record keeping ✓
Others

9. Facilities for specialists consultations :- ——

10. Availability of medical labs :- ——

11. Dispensary :- YES

12. Radiology Services :- ——

13. If so the number of the license issued by the Atomic Energy Authority :- ——

14. Any other facilities (specify) :- —

15. Ownership of premises :- SELF

16. Practicing as a:

General Practitioner: ✓ or Specialist:

If so, what is your speciality? ——

17. Method of Clinical waste disposal :- INCINERATOR

18. Method of sterilization of instruments & dressings :- ELECTRIC STERILIZ

19. Availability of an appointment system? Yes: No: ✓

20. If the application is for renewal whether a copy of the existing registration is attached :- YES

21. The number of the existing certificate of registration :- PHSRC/FGP/ A6 46 49

22. The period of the validity of certificate Upto 31-12-2023

23. Whether fee is paid, if so the original copy of receipt is attached yes ✓ No

I certify that the above information is true and correct. I further declare that the information furnished by me found to be incorrect or false at any stage my application or certificate of registration can be cancelled or suspended by the authority.

Signature of the person operating or maintaining the institution:
Name :- S. POORANACHANDRAN
Designation :- REGD MEDICAL PRACTITIONER
Date :- 10/12/2022