Medical Center Registration Form

Instructions:

1. Please print this form clearly and legibly.
2. Complete all sections accurately and truthfully.
3. Ensure all information provided is current and up-to-date.
4. Attach copies of the following documents to this form:
    - License Certificate
    - Accreditation Certificate: (If applicable)
5. Submit the completed form in the registration

01) Medical Center Information

- Center Name:

  ……

- Phone Number:

  ……

- Email Address:

  ……

- Address:

  ……

- City/Town:

  ……

02) Licensing and Accreditation (Attach the copies to the end of this document)

- License Number:

  …….

- Issuing Authority:

  …….

- License Expiration Date:

  …….

- Accreditation (if any): (e.g., Joint Commission International, Local Accreditation Bodies)

  …….

03) Contact Information

- Primary Contact Name:

  …….

- Primary Contact Phone:

  …….

- Primary Contact Email:

  …….

- Secondary Contact Name (Optional):

  …….

- Secondary Contact Phone (Optional):

  …….

- Secondary Contact Email (Optional):

  …….

04) Declaration

I hereby certify that the information provided above is true and accurate to the best of my knowledge. I understand that providing false information may result in the rejection of my registration and potential legal consequences.

……. …….

Date Signature