



REPUBLIC OF THE PHILIPPINES
Office of Tourism Standards and Regulation
APPLICATION FORM
Tertiary Hospitals

Please print legibly all information required. Do not abbreviate the information supplied. Place "/" marks in appropriate boxes and indicate "N/A" if not applicable.

TO BE FILLED OUT BY DOT AUTHORIZED PERSONNEL ONLY

APPLICATION NUMBER

Application for

- ☐ New Application
- ☐ Renewal

PROCESSED BY

ACCOUNT IDENTIFIER DETAILS

OFFICIAL EMAIL ADDRESS:

TIN:

NOTE:

Make sure that the email address you provided is ACTIVE and VALID. For ESTABLISHMENTS, ensure that this is a corporate email address or an email address that will be permanently associated to your company. Please refrain from using your personal email address as notifications and official communications will be forwarded to your registered email.

ESTABLISHMENT DETAILS

NAME OF HOSPITAL:

BUSINESS ADDRESS:

BUSINESS WEBSITE:

CONTACT NUMBERS:

EMAIL ADDRESS:

DATE ESTABLISHED:

MANAGEMENT DETAILS

OWNERSHIP INFORMATION :

OWNERS'/CORPORATION NAME:

ADDRESS:

NATIONALITY (if applicable):

MANAGING COMPANY INFORMATION (if applicable):

COMPANY NAME:

ADDRESS:

TYPE OF ORGANIZATION	PERMITS			
<input type="checkbox"/> Single Proprietorship	<input type="checkbox"/> Mayor's/Business Permit	Permit No.	Valid Until	
<input type="checkbox"/> Partnership	<input type="checkbox"/> DTI Permit	Permit No.	Valid Until	
<input type="checkbox"/> Corporation	<input type="checkbox"/> SEC/CDA Registration	Permit No.	Valid Until	
<input type="checkbox"/> Cooperative				

GENERAL MANAGER

GENARAL MANAGER'S NAME:

CONTACT NO.

EMAIL ADDRESS:

NATIONALITY:

CAPITALIZATION

	STOCKHOLDER'S NAME	POSITION	NATIONALITY	AMOUNT SUBSCRIBED	AMOUNT PAID UP
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

SPECIFIC DETAILS

Average No. of Patients

Foreign Patients in a Year:

Local Patients in a Year:

Total Number of Rooms

Note: Please account only those intended for Medical Tourism only.

Number of Rooms:

Number of Beds:

AUTHORIZED REPRESENTATIVE (to transact business with DOT)

REPRESENTATIVE'S FULL NAME:

DESIGNATION:

CONTACT NUMBERS:

EMAIL ADDRESS:

As the **General Manager/Chief Executive Officer/Owner** of the above-named establishment, I certify that I have not been convicted of any criminal offense involving moral turpitude and that all the officials and employees of the establishment listed in the attached sheet are of good moral character and without criminal record.

I certify further that all the foregoing data and documents supporting this application are true and correct.

DATE:

Signature over printed name

Position

SUBSCRIBED AND SWORN to before me on this _____ day of _____,
after exhibiting Residence Certificate No. _____ issued at _____ on
_____.

Doc No. _____

Page No. _____

Book No. _____

Series of _____

DOCUMENTARY REQUIREMENTS

Submitted Documents	Evaluator's Remarks
<input type="checkbox"/> Valid Mayor's Permit/Business License	
<input type="checkbox"/> DTI Business Name Certificate (for Sole Proprietor) or SEC Registration Certificate and Articles of Incorporation and its By-Laws (for Partnerships & Corporations) or Articles of Cooperation and Its By-Laws (for Cooperatives)	
<input type="checkbox"/> Valid License to Operate from the Health Facilities Services Regulatory Bureau (HFSRB) of DOT or its equivalent	
<input type="checkbox"/> Other Documents	

REMARKS

FOR DOT USE ONLY

APPLICATION NO.	DATE& TIME RECEIVED	RECEIVED BY	ENCODED BY	REMARKS

Applicants Acknowledgement/Receiving Copy

APPLICATION DETAILS

NAME OF ESTABLISHMENT:			
APPLICATION ID:		DATE & TIME RECEIVED	



DOCUMENTARY REQUIREMENTS

Submitted Documents	Evaluator's Remarks
<input type="checkbox"/> Valid Mayor's Permit/Business License	
<input type="checkbox"/> DTI Business Name Certificate (for Sole Proprietor) or SEC Registration Certificate and Articles of Incorporation and its By-Laws (for Partnerships & Corporations) or Articles of Cooperation and Its By-Laws (for Cooperatives)	
<input type="checkbox"/> Valid License to Operate from the Health Facilities Services Regulatory Bureau (HFSRB) of DOT or its equivalent	
<input type="checkbox"/> Other Documents	

REMARKS

RECEIVED & EVALUATED BY:

Name & Signature of Accreditation Officer

Designation & Unit Assignment

Application No.

Name of Establishment: _____

Employee Count

Department	MANAGERIAL				RANK AND FILE				SUB TOTAL
	LOCAL		EXPAT		LOCAL		EXPAT		
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	
Maintenance and Engineering									0
Food and Beverage									0
Housekeeping									0
Front Office									0
Sales and Marketing									0
Administrative Department									0
Drivers									0
Others									0
TOTAL	0	0	0	0	0	0	0	0	0

Employee List

	LAST NAME	FIRST NAME	M.I.	DESIGNATION	NATIONALITY	ISSUE ID?
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

(Continue on separate sheet if necessary)