REPUBLIC OF THE PHILIPPINES
Office of Tourism Standards and Regulation

APPLICATION FORM

Ambulatory Clinic

TO BE FILLED OUT BY DOT AUTHORIZED PERSONNEL ONLY

APPLICATION NUMBER

Application for

☐ New Application

☐ Renewal

PROCESSED BY

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

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 CLINIC: _____

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		
☐ Single Proprietorship	☐ Mayor's/Business Permit	Permit No.	Valid Until
☐ Partnership	☐ DTI Permit	Permit No.	Valid Until
☐ Corporation	☐ SEC/CDA Registration	Permit No.	Valid Until
☐ 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:

Services Offered

- ☐ Cosmetic Dentistry
- ☐ Cosmetic Procedure
- ☐ Dermatology
- ☐ Opthalmologic Surgery
- ☐ Plastic Reconstructive Surgery
- ☐ Other Services, Please specify: _____

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 douments 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
☐ Valid Mayor's Permit/Business License	
☐ 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)	
☐ Valid License to Operate from the Health Facilities Services Regulatory Bureau (HFSRB) of DOT or its equivalent	
☐ 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
☐ Valid Mayor's Permit/Business License	
☐ 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)	
☐ Valid License to Operate from the Health Facilities Services Regulatory Bureau (HFSRB) of DOT or its equivalent	
☐ Other Documents	

REMARKS

RECEIVED & EVALUATED BY:

_____ _____

Name & Signature of Accreditation Officer *Designation & Unit Assignment*

Application No. _____

Name of Clinic: _____

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)