REPUBLIC OF SOMALILAND
NATIONAL HEALTH PROFESSIONS COMMISSION

JAMHURIYADDA SOMALILAND
KOMISHANKA QARANKA MIHNADAHA CAAFIMAADKA

BADDA CAS AREA - HARGEISA, SOMALILAND
Tel: +252-2-571283 / Email: info@nhpcsomaliland.org / Website: nhpcsomaliland.org

THE REPUBLIC OF SOMALILAND

APPLICATION FOR THE REGISTRATION OF A HEALTH CARE FACILITY

NB: AN INCOMPLETE FORM WILL DELAY REGISTRATION

Please PRINT and Return the Original Form to NHPC Office

For Office Use Only

Received on: _____

Amount SL.SH: _____

Receipt No: _____

Reg. No: _____

Reg. Date: _____

Assessed by: _____

Date: _____

Signature: _____

Verified by: _____

Date: _____

Signature: _____

A. Facility Information

1. Facility Name: .....
2. Address: .....
3. Telephone: .....
4. Website: .....
5. Established Date: .....
6. Current Registration Number: .....
7. Authorizing Department: .....
8. Type of Facility: .....

i. a) Public: ☐ b) Private: ☐ c) Private For Non-Profit: ☐
Others (Specify): .....

ii. a) Teaching Hospital: ☐ b) University Affiliated Hospital: ☐

B. Facility Director's Information

1. Director Name: .....
2. Director's Title: .....
3. Field of study/Specialty: .....
4. Registration No (Only for Medical Personnel): .....
5. Telephone: .....
6. Email: .....

C. Locality of Health Unit

1. County/Area: .....
2. City/Town/Village: .....
3. District: .....
4. Region: .....

1. Do you own the property? Yes ☐ No ☐

   a) If yes (Please attach a photocopy of prove of ownership.

   b) If no attach tenancy agreement.

   c) Others (Specify):.....

D. VISION, MISSION, OBJECTIVES AND CORE VALUES

1. State the vision of the health care institution:
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   .....
   .....
   .....
2. State the mission of the health care institution:
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3. State the objectives of the health care institution:
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   .....
4. State the core values of the health care institution:
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E. GOVERNANCE AND MANAGEMENT STRUCTURES

1. State the governance structure of the health care institution:
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2. State the management structure of the health care institution:
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   .....

F. INSTITUTIONAL RESOURCES

1. List the names, titles and qualifications of the human resources that are available to manage/operate the health care institution: If more space is needed, use an additional sheet and attach it to this form:

Name	Title	Qualifications

1. State the current sources of funding for the health care institution:
   .....
   .....
   .....
   .....
2. State expected sources of funding for the health care institution:
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G. INSTITUTIONAL INFRASTRUCTURE AND FACILITIES AVAILABLE

1. State the existing infrastructure (such as number of wards, rooms, offices, toilets, and patient waiting areas etc).
   .....
   .....
   .....
   .....
   .....

H. Category of Health Facility (Tick✓ One)

Note: Use the below chart sheet to select the appropriate categories class:

A| B| C| |D (Please Tick the Appropriate Class)

Class A: (Such as; National and Regional Hospitals)	**Class B** (Such as; Referral and District Hospitals)	**Class C** (Such as; Health Centers and MCHs))	**Class D** (Such as Diagnostic Centers)
1. Management 2. Human Resources 3. Medical Records 4. Facility Maintenance 5. Equipment Management 6. Fire And Safety 7. Infection Prevention Plan 8. Supplies 9. Laboratory 10. Sterilization process 11. Waste management. 12. Medications 13. Pharmacy 14. Clinical Practice 15. Radiology/Imaging Services 16. Dentistry 17. Rehabilitation 18. Quality Assurance 19. Blood Bank 20. Operating Rooms/ Anesthesia 21. Emergency Services 22. IT Services	1. Management 2. Human Resources 3. Medical Records 4. Facility Maintenance 5. Equipment Maintenance 6. Fire And Safety 7. Infection Prevention Plan 8. Supplies 9. Laboratory 10. Sterilization process 11. Waste management. 12. Medications 13. Pharmacy 14. Clinical Practice 15. Radiology/ Imaging Services 16. Dentistry 17. Rehabilitation 18. Quality Assurance	1. Management 2. Human Resources 3. Medical Records 4. Facility Maintenance 5. Equipment Maintenance 6. Fire And Safety 7. Infection Prevention Plan 8. Supplies 9. Laboratory 10. Sterilization process 11. Waste management. 12. Medications 13. Pharmacy 14. Clinical Practice .	1. Management 2. Human Resources 3. Medical Records 4. Facility Maintenance 5. Equipment Maintenance 6. Fire and Safety 7. Infection Prevention Plan 8. Supplies 9. Laboratory 10. Sterilization process 11. Waste management.

A) Hospital/Referral/Regional Hospital

Number of Beds ☐

Tick All Available Departments: *For additional departments fill the spaces provided*

Cardiology		Gynecology & Obstetrics		Pediatric		Diagnostic Imaging	
Dental		Medical		Physiotherapy		Urology	
Dermatology		Neurology		Psychiatric		Laboratory	
ENT		Nephrology		Pharmacy		A & E depart.	
Ophthalmology		Orthopedic		Surgical		Others	

B. Hospital/Health Center:

Number of Beds: ☐

Tick All Available Departments: *For additional departments fill the spaces provided*

Cardiology		Gynecology & Obstetrics		Pediatric		Diagnostic Imaging	
Dental		Medical		Physiotherapy		Urology	
Dermatology		Neurology		Psychiatric		Laboratory	
ENT		Nephrology		Pharmacy		A & E depart.	
Ophthalmology		Orthopedic		Surgical		Others	

C. Health Centers and MCHs

Number of Beds: ☐

Tick All Available Departments: *For additional departments fill the spaces provided*

EPI/ Immunization		Basic Laboratory		< 5yrs & > 5yrs OPD		Outreach Services	
Nutrition Program		Antenatal care		Postnatal care		VCT	
Delivery Unit		OPD		Pharmacy		Others	

D. Diagnostic Centers ☐

I. PARTICULARS OF OWNERS (if not government owned)

NB: *If more space is needed or the organization has shareholders please attach the list*

Name……Tel……

Signature……Date……

Name……Tel……

Signature……Date……

Name……Tel……

Signature…… ……Date……

Name……Tel……

Signature…… ……Date……

Name……Tel……

Signature…… ……Date……

Name……Tel……

Signature…… ……Date……

Name……Tel……

Signature…… ……Date……

Facility Director/Manager/CEO:

Name: ……

Title: ……

Signature…… ……Date……

NB: In support of your application, please attach the following required documents to this application.

1. A list of equipment and material.
2. Prove of ownership or tenancy agreement.
3. Prove of business or public registration.
4. Constitution/Article of Association.
5. Strategic plan/business plan (with financial and operational manuals/policies).
6. Prove of current Registration from.
7. Final report of NHPC facility assessment (If assessed by NHPC).
8. A copy of Registrations and Licensure of health care workforce employed by the institution *(such as Doctors, Nurses, Midwifes and other Allied health workers).*
9. Any other supporting document requested by NHPC.

FOR OFFICIAL USE ONLY

Regulatory Officer:

Full name:

Comments:

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Date ***(DD/MM/YYYY):*** Signature:

Executive Director:

Full Name

Comments

……

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Recommended ☐ **Not Recommended** ☐

Date ***(DD/MM/YYYY):*** Signature:

NHPC Chair Person:

Full Name:

Comments

……

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Approved ☐ **Not Approved** ☐

Date *(DD/MM/YYYY):* Signature: