Ministry of Healthcare and Nutrition

REGISTRATION FORM FOR PRIVATE MEDICAL LABORATORIES

REGISTRATION NO: ☐

Official use only

GENERAL INFORMATION

1. Name of the Medical lab -

2.
   a) Address -
   b) Telephone no. -
   c) E-mail -

3. Name of the person operating/ maintaining the lab -
   a. The relationship with the lab –
   b. Address -
   c. General Telephone –
   d. Fax no.-
   e. E-mail address -
   f. Web site address (if available) -

4. Location of the lab –

Province	
District	

5. Type of the lab-
   a. Automated ☐
   b. Semi Automated ☐
   c. Mobile lab ☐
   d. Collecting center ☐

6. **Ownership status –** *(Tick on appropriate cage)*

   a. Public company ☐
   b. Private company ☐
   c. Proprietary private lab ☐
   d. Cooperative hospital lab ☐
   e. Estate owned hospital lab ☐

   f. Other ……..

7. Date of Establishment – ☐

8. Business registration no.- ☐

9.i. ***Administration staff***

Designation	Name	Contact tel. no.
Chairman	…….	
CEO/Managing Director	…….	
Administrative Officer	…….	
Accountant	…….	
Other Major Staff	…….	

ii. The details of the medical staff including Doctors, Consultants engaged in the profession under this institution to be provided as an annexure -

Lab staff -

1. Pathologist –
2. MLTT (*attach a copy of SLMC Registration certificate.)* -
3. Qualifications
4. SLMC Registration no.
5. The country and the Medical College where the degree/ post graduation was obtained -

iii. Whether employed in government or private –
If government the name of the medical institution and the post held currently.

10. Facilities available -

11. Machinery/ equipment available –
    a. Medical machinery -

12. Method of waste disposal -

13. Whether Radiology facilities are available -

14. If so the number of the license issued by the Atomic Energy Authority -

15. If the application is for renewal whether a copy of the existing registration is attached –

16. The number of the existing certificate of registration –

17. The period of the validity of certificate | Up to |

18. 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: -
Designation: - Date:

Return after completion through the relevant Provincial Director of Health Services to,

Secretary,
Private Health Services Regulatory Council,
Ministry of Healthcare and Nutrition,
"Suwasiripaya",
385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo - 10.
Sri Lanka.
Tel: 0112674680

The above application is forwarded herewith

Signature Seal ……

The relevant Provincial Director of Health Services Date