PROVIDER REGISTRATION FORM (FORM 03)

1. **NAME OF FACILITY** ……………………………………………………………………………………

2. **ADDRESS OF FACILITY** ……………………………………………………………………………………

3. **PARTICULARS OF MEDICAL DIRECTOR**

E-MAIL ……………………………………………………………………………………

TELEPHONE ……………………………………………………………………………………

NAME ……………………………………………………………………………………

MDCN NO ……………………………………………………………………………………

GSM NO ……………………………………………………………………

4. **PASSPORT PHOTOGRAPHS OF DIRECTORS**

5. **INSURANCE COMPANY PROVIDING:**

Professional indemnity cover

Insurance company: ____

Address: ____

______________________________ Tel: ______________________________

Amount: ______________________________ Expiration Date: ______________________________

Policy Date: ______________________________ Policy No: ______________________________

6. MEDICAL PERSONNEL DATA

Doctors /GP'S

NAME	MDCN NO.	GSM NO.
1.		
2.		
3.		
4.		
5.		

NAME	MDCN NO.	GSM NO.	SPECIALITY
1			
2			
3			

Name of Trained Nurses	Registration Number
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Pharmacist/GSM No.

☐ PERSONNEL/OTHERS

ADMIN	
1. Hospital Secretary/Administration	

BANK NAME……

ACCOUNT NAME………

CURRENT ACCOUNT NO………..

________________________ ________________________

Name and Signature Date

Note: Please attach photocopies of relevant documents