For Office Use Only
CPQ ID:
Date Submitted:

Initial Application Form - Hospital

All fields marked with * in this application form are mandatory fields. CPQ will not accept any application which does not have these mandatory fields completed. All relevant sections of this application form shall be completed including supporting documents where indicated and the Declaration and Signature. For any changes to this application (e.g. proposed services, space and equipment, or other) please submit a new application.

Particulars of Premises

Proposed Operational Names (Provide 3 options in the order of preference as applicable - name options are subject to availability and validation) *

1	
2	
3	

Project*	Plot No.*	No of Floors (B+G+F)*	GFA (in sq ft) *

Expected Date of Operation *

Categories of Facility

☐	General
☐	Specialty
☐	Rehabilitation
☐	Hospice/Pallative Care
☐	Geriatric Care
☐	Long Term Care/ Nursing Home
☐	Other (……)

Bed Capacity

Select	Type	Number
☐	Medical	
☐	Surgical	
☐	Specialty 1 (……)	
☐	Specialty 2 (……)	
☐	Specialty 3 (……)	
☐	Day Surgery	
☐	ICU/CCU	
☐	Nursery (Cots)	
☐	Special Care Nursery (Cots)	
☐	NICU (Cots)	
☐	Other 1 (……)	
☐	Other 2 (……)	
☐	Other 3 (……)	
	Total Proposed Bed Capacity	

Facility Legal Status	
☐	Free Zone Limited Liability Company (FZ-LLC)
☐	Branch of a UAE registered Company
☐	Branch of a Foreign registered Company
☐	Developer

Where the shareholder is a registered company please attach the Certificate of Incorporation of the Parent Company

Particulars of Applicant (owner/tenant of proposed facility and/ or main shareholder)		
Provide passport copy attached to this application		
Name (as shown in the passport (include title))*		
Address *		Postal Code (ZIP)
P.O. Box *	City *	Country *
Landline *	Fax *	Mobile *
Email 1*		
Email 2*		

Particulars of Facility Operator (Where different to the Applicant)		
Provide passport copy attached to this application		
Name (as shown in the passport (include title))*		
Address *		Postal Code (ZIP)
P.O. Box *	City *	Country *
Landline *	Fax *	Mobile *
Email 1*		
Email 2*		

Particulars of Assigned Contact Person (Where different to the Applicant)		
Provide passport copy attached to this application		
Name (as shown in the passport (include title))*		
Address *		Postal Code (ZIP)
P.O. Box *	City *	Country *
Landline *	Fax *	Mobile *
Email 1*		
Email 2*		

Particulars of Other Representatives 1 (Director 1 as applicable)		
Provide passport copy attached to this application		
Name (as shown in the passport (include title))*		
Address *		Postal Code (ZIP)
P.O. Box *	City *	Country *
Landline *	Fax *	Mobile *
Email *		

Particulars of Other Representatives 2 (Director 2 as applicable)		
Provide passport copy attached to this application		
Name (as shown in the passport (include title))*		
Address *		Postal Code (ZIP)
P.O. Box *	City *	Country *
Landline *	Fax *	Mobile *
Email *		

Medical Services		
Note : Selected services shall require appropriate CPQ licensed professional, allied health and clinical support staff		
	Outpatient	Procedures
General Medicine		
General Medicine	☐	☐
Medical / Dental Specialties		
Allergy & Immunology		
Allergy & Immunology	☐	☐
Anesthesiology		
Anesthesiology	☐	☐
Critical Care Medicine	☐	☐
Hospice and Palliative Medicine	☐	☐
Pain Medicine	☐	☐
Colon and Rectal Surgery		
Colon and Rectal Surgery	☐	☐
Dentistry		
General Dentistry	☐	☐
Dental Public Health	☐	☐
Endodontics	☐	☐
Oral & Maxillofacial Pathology	☐	☐
Oral & Maxillofacial Radiology	☐	☐
Oral & Maxillofacial Surgery	☐	☐
Orthodontics & Dentofacial Orthopedics	☐	☐
Pediatric Dentistry	☐	☐
Periodontics	☐	☐
Prosthodontics	☐	☐

	Outpatient	Procedures
Dermatology		
Dermatology	☐	☐
Clinical & Laboratory Dermatological Immunology	☐	☐
Dermatopathology	☐	☐
Pediatric Dermatology	☐	☐
Emergency Medicine		
Emergency Medicine	☐	☐
Hospice and Palliative Medicine	☐	☐
Medical Toxicology	☐	☐
Pediatric Emergency Medicine	☐	☐
Emergency Medicine		
Sports Medicine	☐	☐
Undersea and Hyperbaric Medicine	☐	☐
Family Medicine		
Family Medicine	☐	☐
Adolescent Medicine	☐	☐
Geriatric Medicine	☐	☐
Hospice and Palliative Medicine	☐	☐
Sleep Medicine	☐	☐
Sports Medicine	☐	☐
Internal Medicine		
Internal Medicine	☐	☐
Adolescent Medicine	☐	☐
Advanced Heart Failure and Transplant Cardiology	☐	☐
Cardiovascular Disease	☐	☐
Clinical Cardiac Electrophysiology	☐	☐
Critical Care Medicine	☐	☐
Endocrinology, Diabetes & Metabolism	☐	☐
Gastroenterology (No.of Procedure Rooms _____)	☐	☐
Geriatric Medicine	☐	☐
Hematology	☐	☐
Hospice and Palliative Medicine	☐	☐
Infectious Diseases	☐	☐
Interventional Cardiology	☐	☐
Medical Oncology	☐	☐
Nephrology (No. of Dialysis Chairs_____)	☐	☐
Pulmonary Disease	☐	☐
Rheumatology	☐	☐
Sleep Medicine	☐	☐
Sports Medicine	☐	☐
Transplant Hepatology	☐	☐
Medical Genetics		
Clinical Biochemical Genetics	☐	☐
Clinical Cytogenetics	☐	☐
Clinical Genetics (MD)	☐	☐
Clinical Molecular Genetics	☐	☐
Medical Biochemical Genetics	☐	☐
Molecular Genetic Pathology	☐	☐

	Outpatient	Procedures
Neurological Surgery		
Neurological Surgery	☐	☐
Nuclear Medicine		
Nuclear Medicine	☐	☐
Obstetrics & Gynecology		
Obstetrics & Gynecology	☐	☐
Obstetrics & Gynecology		
Critical Care Medicine	☐	☐
Hospice and Palliative Medicine	☐	☐
Maternal & Fetal Medicine	☐	☐
Reproductive Endocrinology/Infertility	☐	☐
Ophthalmology		
Ophthalmology	☐	☐
Orthopaedic Surgery		
Orthopaedic Surgery	☐	☐
Orthopaedic Sports Medicine	☐	☐
Surgery of the Hand	☐	☐
Podiatry Medicine	☐	☐
Otolaryngology		
Otolaryngology	☐	☐
Neurotology	☐	☐
Paediatric Otolaryngology	☐	☐
Plastic Surgery Within the Head and Neck	☐	☐
Sleep Medicine	☐	☐
Pathology		
Pathology	☐	☐
Anatomic Pathology & Clinical Pathology	☐	☐
Pathology – Anatomic	☐	☐
Pathology – Clinical	☐	☐
Blood Banking/Transfusion Medicine	☐	☐
Cytopathology	☐	☐
Dermatopathology	☐	☐
Neuropathology	☐	☐
Pathology - Chemical	☐	☐
Pathology - Forensic	☐	☐
Pathology - Hematology	☐	☐
Pathology - Medical Microbiology	☐	☐
Pathology - Molecular Genetic	☐	☐
Pathology - Paediatric	☐	☐
Paediatrics		
Paediatrics	☐	☐
Adolescent Medicine	☐	☐
Child Abuse Paediatrics	☐	☐
Developmental-Behavioral Paediatrics	☐	☐
Hospice and Palliative Medicine	☐	☐
Medical Toxicology	☐	☐
Neonatal-Perinatal Medicine	☐	☐
Neurodevelopmental Disabilities	☐	☐
Paediatric Cardiology	☐	☐

	Outpatient	Procedures
Paediatrics		
Paediatric Critical Care Medicine	☐	☐
Paediatric Emergency Medicine	☐	☐
Paediatric Endocrinology	☐	☐
Paediatric Gastroenterology	☐	☐
Paediatric Hematology-Oncology	☐	☐
Paediatrics		
Paediatric Infectious Diseases	☐	☐
Paediatric Nephrology (No.of Chairs_____)	☐	☐
Paediatric Pulmonology	☐	☐
Paediatric Rheumatology	☐	☐
Paediatric Transplant Hepatology	☐	☐
Sleep Medicine	☐	☐
Sports Medicine	☐	☐
Physical Medicine & Rehabilitation		
Physical Medicine & Rehabilitation	☐	☐
Hospice and Palliative Medicine	☐	☐
Neuromuscular Medicine	☐	☐
Pain Medicine	☐	☐
Paediatric Rehabilitation Medicine	☐	☐
Spinal Cord Injury Medicine	☐	☐
Sports Medicine	☐	☐
Plastic Surgery		
Plastic Surgery	☐	☐
Plastic Surgery Within the Head and Neck	☐	☐
Surgery of the Hand	☐	☐
Preventive Medicine		
Aerospace Medicine	☐	☐
Occupational Medicine	☐	☐
Public Health & General Preventive Medicine	☐	☐
Medical Toxicology	☐	☐
Undersea & Hyperbaric Medicine	☐	☐
Psychiatry & Neurology		
Psychiatry	☐	☐
Neurology	☐	☐
Neurology with Special Qualifications in Child Neurology	☐	☐
Addiction Psychiatry	☐	☐
Child & Adolescent Psychiatry	☐	☐
Clinical Neurophysiology	☐	☐
Forensic Psychiatry	☐	☐
Geriatric Psychiatry	☐	☐
Hospice and Palliative Medicine	☐	☐
Neurodevelopmental Disabilities	☐	☐
Neuromuscular Medicine	☐	☐
Pain Medicine	☐	☐
Psychosomatic Medicine	☐	☐
Sleep Medicine	☐	☐
Vascular Neurology	☐	☐

	Outpatient	Procedures
Radiology		
Diagnostic Radiology	☐	☐
Radiation Oncology	☐	☐
Radiologic Physics	☐	☐
Hospice and Palliative Medicine	☐	☐
Neuroradiology	☐	☐
Nuclear Radiology	☐	☐
Paediatric Radiology	☐	☐
Vascular and Interventional Radiology	☐	☐
Rehabilitation/Hospice Care		
	Services	
Geriatric Care	☐	
Hospice/Palliative Care	☐	
Long Term Care	☐	
Nursing Home Care	☐	
Rehabilitation Care	☐	
Surgery		
General Surgery	☐	☐
Vascular Surgery	☐	☐
Hospice and Palliative Medicine	☐	☐
Paediatric Surgery	☐	☐
Surgery of the Hand	☐	☐
Surgical Critical Care	☐	☐
Thoracic Surgery		
Thoracic Surgery	☐	☐
Congenital Cardiac Surgery	☐	☐
Urology		
Urology	☐	☐
Paediatric Urology	☐	☐
Medical Specialties – Others		
a.	☐	☐
b.	☐	☐
c.	☐	☐
d.	☐	☐

Clinical Support Services		
Audiology	☐	
Cosmetology/Aesthetics	☐	
Cancer Immunotherapy	☐	
Cardiac Rehabilitation	☐	
Cardiac Diagnostics	☐	
Counseling	☐	
Dental Laboratory	☐	
Dialysis	☐	
Endoscopy (Gastroscopy and/or Colonoscopy)	☐	
Laser Therapy	☐	
Medical Physics	☐	
Neurological Rehabilitation	☐	
Neurological Diagnostics	☐	
Nuclear Radiology Imaging	☐	
Nutrition	☐	
Ophthalmic Imaging	☐	

Clinical Support Services		
Optometry	☐	
Orthotics & Prosthetics	☐	
Physical Therapy	☐	
Podiatry	☐	
Radiology & Medical Imaging	☐	
Respiratory Therapy	☐	
Regenerative Medicine Therapy	☐	
Speech Language Therapy	☐	
Sleep Medicine Technology	☐	
Ultrasonography	☐	
Occupational Health Therapy	☐	
Pulmonary Function Technology	☐	
Psychology	☐	
Behaviour consultation and assessment	☐	
Clinical Support Services – Other 1_____	☐	
Clinical Support Services – Other 2_____	☐	
Clinical Support Services – Other 3_____	☐	

Pharmacy Services
Indicate whether Pharmacy Services include retail services
☐ Inpatient Only ☐ Include retail services

Laboratory Services		
Indicate whether Laboratory Services include services to external healthcare providers		
☐ Internal Only ☐ Services include those to external healthcare providers		
Note : DHCC Rules and Regulations require a Hospital laboratory to be Accredited in the within the first operational year		
Antenatal Screening Test	☐	
Assisted Reproductive Technology (ART)	☐	
Blood Banking	☐	
Clinical Biochemistry	☐	
Hematology	☐	
Histopathology & Cytology	☐	
Hormonal Assays	☐	
Immunology	☐	
Mycology	☐	
Virology	☐	
Molecular Biology	☐	
Parasitology	☐	
Serology	☐	
Toxicology	☐	
Microbiology	☐	
Cytogenetics	☐	
Analytical Chemistry	☐	
Lab – Others 1 _____	☐	
Lab – Others 2 _____	☐	
Lab – Others 3 _____	☐	

Complementary & Alternative Medicine (CAM)		
Ayurveda	☐	
Acupuncture	☐	
Cupping	☐	

Complementary & Alternative Medicine (CAM)		
Chiropractic	☐	
Guided Imagery	☐	
Homeopathy	☐	
Naturopathy	☐	
Naturopathy	☐	
Osteopathy	☐	
Pilates	☐	
Tai Chi	☐	
Therapeutic Massage	☐	
Traditional Chinese Medicine	☐	
Unani Medicine / Eastern Medicine	☐	
Yoga	☐	
CAM – Others 1 _____	☐	
CAM – Others 2 _____	☐	
CAM – Others 3 _____	☐	

Operating Rooms

It is intended to provide operating rooms equipped for invasive surgical procedures?

☐ Yes ☐ No ☐ N/A

Number of proposed Operating Rooms _____

Number of Procedures per Month _____

Select		Surgical Facility Classes defined by the American College of Surgeons
Class A	☐	Provides for minor surgical procedures performed under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation. Excluded are spinal, epidural axillary, stellate ganglion blocks, regional blocks (such as interscalene), supraclavicular, infraclavicular, and intravenous regional anesthesia
Class B	☐	Provides for minor or major surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs
Class C	☐	Provides for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.

Surgical Procedures

Provide a list of primary surgical procedures to be performed at the facility for each selected service where applicable. Indicate whether procedures are invasive or non-invasive as applicalble (attach a separate sheet where necessary)

Surgical Procedures (continued)

Provide a list of primary surgical procedures to be performed at the facility for each selected service where applicable. Indicate whether procedures are invasive or non-invasive as applicalble (attach a separate sheet where necessary)

Medical Equipment

Select/add on-site major medical equipments and any specific building/site service requirements

Equipment	
Densitometers, Bone	
Digital Imaging Systems, Angiographic/Cardiovascular	
EEG Monitors; Electroencephalograph	
Lasers, Carbon Dioxide, Surgical/Dermatologic	
Linear Accelerators; Radiotherapy Units	
Lithotripters, Extracorporeal	
Radiographic Units, Dental; Digital	
Radiographic Units, Mammographic	
Radiographic/Fluoroscopic Systems, General Purpose	
Recorders, Graphic, Evoked-Potential; Electromyographs; Electronystagmographs	
Scanning Systems, Cardiac; Intravascular	
Scanning Systems, Computed Tomography (CT), Full Body	
Scanning Systems, Gamma Camera	
Scanning Systems, General Purpose	
Scanning Systems, Magnetic Resonance Imaging (MRI)	
Scanning Systems, Positron Emission Tomography (PET)	
Angiography - Catheter Laboratory	
Ultrasound	
Echo Doppler	
Sterilizing Units,	
Video Endoscopy System	
Washer/Decontaminators	
Others	
a.	
b.	
c.	
d.	

Building/Site Services Requirements

Provide specific site services requirements for selected major medical equipment (e.g. mechanical, electrical, plumbing and building services)

Current Experience and/or Operations

Provide copy of healthcare facility operating license from relevant licensing authority as applicable ((attach a separate sheet where necessary)

Name	Location	Period
a.		
b.		
c.		
d.		

Number of Professionals per Specialty/per Qualification - as applicable

List all professionals and numbers planned for the facility at start up and when fupply operational

Physicians

	Number Of	
Specialty	Start Up	Fully Operational

Nurses

	Number Of	
	Start Up	Fully Operational
Registered Nurses		
Nurse Assistants		
Other 1		
Other 2		

Allied Health

	Number Of	
	Start Up	Fully Operational
	Start Up	**Fully Operational**
Total Number of Proposed Professional Staff Staff		

Support Services

Indicate which support services are to be provided on site/off site or both and where applicable outsourced

Services	On Site		Outsourced		
	On	Off	Yes	No	Part
Catering and Dietary Services	☐	☐	☐	☐	☐
Laundry Services	☐	☐	☐	☐	☐
CSSD	☐	☐	☐	☐	☐
Materials Management	☐	☐	☐	☐	☐
Mortuary	☐	☐	☐	☐	☐
Engineering and Biomedical	☐	☐	☐	☐	☐
Security	☐	☐	☐	☐	☐
Houeskeeping	☐	☐	☐	☐	☐
Health Records	☐	☐	☐	☐	☐
Waste Management	☐	☐	☐	☐	☐
Materials Management	☐	☐	☐	☐	☐
Other 1 _____	☐	☐	☐	☐	☐
Other 2 _____	☐	☐	☐	☐	☐
Other 3 _____	☐	☐	☐	☐	☐

Total Number of Proposed Support Staff _____

Education and Research Activities

Please indicate if you plan to initiate any medical research activities?

☐ Yes ☐ No

If Yes, you are required to complete an Initial Application Form for an Education and Research Permit (please request form from CPQ)

Note: if any research will be performed, your application will be forwarded to the Offices for Academic Affairs and Research Administration. This will not delay or impact your clinical application process.

Please indicate if you plan to engage in any medical educational and/ or teaching activities with the exception of internal training to employees and patient education?

☐ Yes ☐ No

If Yes, you are required to complete an Initial Application Form for an Education and Research Permit (please request from CPQ)

Note: Prior to engaging in any medical education and/or research activities, you will be required to complete the an Initial Application for Education and Research and receive approval from the DHCC Academic and Research Council

Supporting Documents Check List

☐	Feasability Study and Functional Program - refer to Application Notes
☐	CV's of Management Team
☐	Passport Copies (refer to sections for Applicant particulars)
☐	Additonal information requested in sections of this form
☐	Where the shareholder is a registered company provide a copy of the Certificate of Incorporation from the Parent Company

Application - Notes

Note	All relevant sections of this application form shall be completed including supporting documents where indicated and the declaration and signature
Note	All healthcare organizations are required to agree to certain standards, covenants, and operating procedures. These include adhering to quality and planning requirements, participating in ongoing quality improvement programs, and fulfilling requirements for continuing medical education by physicians and allied staff.
Note	Application fees payment are attached in accordance with CPQ Fees Schedule - Fees are non refundable should an application be rejected
Note	FZ-LLC applicants are restricted from opening a branch withiin the UAE including any other free zone areas.
Note	The transfer of shares in any FZ-LLC company licensed in DHCC is not allowed for the first year of incorporation
Note	CPQ for additional specialities
Note	Refer to DHCC Decision 1 Concerning Commercial Licensing Categories in DHCC licensing fee schedules
Note	Following admission to DHCC the applicant must: * Maintain the quality standards adopted by CPQ and participate in the mandatory audit requirements * Maintain the licensing, credentialing, clinical privileges, and continuing medical education of all healthcare and CAM healthcare professionals * Abide by all Regulations, Rules, Policies and Standards established by CPQ , which may change from time to time * All healthcare professionals and CAM healthcare professionals must be compliant with CPQ Professional Licensing Regulations
Note	DHCC Rules and Regulations require a Hospital to be Accredited within 2 years from becoming operational

Feasability Study and Functional Program - As per the selected services identified in this application - provide a clinical functional brief which identifies how each service will be provided and managed , including dependencies from other clinical and support departments.
The functional program shall also describe the following where applicable:

Operator
The healthcare operator's, company or institution responsible for the establishment and management of the facility
The healthcare operators previous and current operations experience
Major owner/shareholders
Executive Management Team Competencies
Professional Support Requirements

Staff and Training
Manpower plan including staffing over the initial 5 year period of operation, identifies the number of professionals, nurses and allied health staff .
This should relate to the type and number of patients with staff recruitment and training needs identified

Patients
The anticipated inpatients in the first 3 years of operation including patients per day and bed occupancy
Per specialty the number of admissions, outpatient appointments
Emergency Department attendences (as applicable)

Functional Space
A description of each functional area per floor including clinical and non clinical services
How clinical units will operate with relationships of patient and staff flow plans
The separation of dirty and clean activities and conformity with best design practices

Marketing
Proposed market segments share and marketing strategies (use population forecasts as required)
Demographics, disease patterns, forecast demand and supply dynamics
Critical Success Factors
Competition and Risk Analysis
Strategic Alliances
Regional factors and condtions

Finance
Financial Modelling and planning
Capital Resources and investment strategies (project and projected operational expenditure)
Assumptions (Year 1- 5) - income, balance sheet, cash flows, break even analysis

Application - Notes (continued)

Project

Building project major milestones
Anticiipated Practical Completion and Occupancy Dates
Key Assumptions
Zoning Authority Requirements
Oher Authorities Having Jurisdiction Requirements (e.g. MOH, DM, RTA, RERA, DEWA, District Cooling, etc)
Expansion capacity
Medical Equipment and Furniture Planning and Review
Impact on existing facility and services - as applicable
Design Standards - minimum American Institute of Architects (AIA), LEED requirements
Environmental Impact Review and Analysis - Green Construction Practices

Declaration and Signature

* I declare that I am authorized to represent the applicant in this request to operate a facility proposed in this application

* I have read all of the requirements listed in this application and the attached fee schedule. I understand that the application fee once paid is non-refundable and that the fee schedule may change without prior notice.

* I understand that approval of the license is dependent on satisfactory compliance with the relevant CPQ/DHCC Departments including Registration and Licensing for obtaining a Commercial License and leasing

* I declare there are no existing or pending litigation matters, claims, penalties, proceedings or investigations by any professional body against any healthcare professional currently working at my existing facility or facilities.

* I declare the information in my application to be true, to the best of my knowledge.

* I understand that CPQ will contact me if additional information is required to complete my application. I am aware that I must authorize any additional contact for this application without which CPQ will not release any information.

* I acknowledge that I have been fully informed of the DHCC/CPQ healthcare professional licensing requirements. I understand that all healthcare professionals at the facility must be licensed by DHCC/CPQ and that the Clinical Operating Permit approval for the facility is dependent on meeting these requirements

* I understand that any fraudulent, misleading, deceptive or incorrect information provided will result in any approval issued being revoked. Further, any payments made for the purpose of that approval will not be refunded.

* CPQ reserves the right to refuse, at its sole discretion, any application.

_____ _____

Signature **Date**