



*For Office Use Only*

CPQ ID:

Date Submitted:

**Initial Application Form - Clinical Facility**

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.

**Categories of Facility**

<input type="checkbox"/>	Single Specialty Clinic
<input type="checkbox"/>	Multi Specialty Clinic
<input type="checkbox"/>	Surgical Center - Number of Operating Theatres : _____
<input type="checkbox"/>	Clinical Support
<input type="checkbox"/>	Diagnostic Center - Clinical Laboratory and/or Radio diagnostic
<input type="checkbox"/>	Pharmacy

**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 the Facility Manager (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 the 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 \*

**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

**Proposed Location** (including building, floor and unit number) \*

**Proposed Space** (in sq ft) \*





### Facility Legal Status

<input type="checkbox"/>	Free Zone Limited Liability Company (FZ-LLC)
<input type="checkbox"/>	Branch of a UAE registered Company
<input type="checkbox"/>	Branch of a Foreign registered Company
<input type="checkbox"/>	Developer

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

### Classification of Surgical Facility

Surgical Facility Classes defined by the American College of Surgeons

Class A	<input type="checkbox"/>	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	<input type="checkbox"/>	Provides for minor or major surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs
Class C	<input type="checkbox"/>	Provides for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.
Consultation Only	<input type="checkbox"/>	No anesthesia permitted on site

### Medical Services

**Note :** Selected services shall require appropriate CPQ licensed professional, allied health and clinical support staff

	Consultation	Procedures
<b>General Medicine</b>		
General Medicine	<input type="checkbox"/>	<input type="checkbox"/>
<b>Medical / Dental Specialties</b>		
<b>Allergy &amp; Immunology</b>		
Allergy & Immunology	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anesthesiology</b>		
Anesthesiology	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Hospice and Palliative Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Pain Medicine	<input type="checkbox"/>	<input type="checkbox"/>
<b>Colon and Rectal Surgery</b>		
Colon and Rectal Surgery	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dentistry</b>		
General Dentistry	<input type="checkbox"/>	<input type="checkbox"/>
Dental Public Health	<input type="checkbox"/>	<input type="checkbox"/>
Endodontics	<input type="checkbox"/>	<input type="checkbox"/>
Oral & Maxillofacial Pathology	<input type="checkbox"/>	<input type="checkbox"/>
Oral & Maxillofacial Radiology	<input type="checkbox"/>	<input type="checkbox"/>
Oral & Maxillofacial Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontics & Dentofacial Orthopedics	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Dentistry	<input type="checkbox"/>	<input type="checkbox"/>
Periodontics	<input type="checkbox"/>	<input type="checkbox"/>
Prosthodontics	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dermatology</b>		
Dermatology	<input type="checkbox"/>	<input type="checkbox"/>
Clinical & Laboratory Dermatological Immunology	<input type="checkbox"/>	<input type="checkbox"/>
Dermatopathology	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Dermatology	<input type="checkbox"/>	<input type="checkbox"/>



	Consultation	Procedures
<b>Emergency Medicine</b>		
Emergency Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Hospice and Palliative Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Medical Toxicology	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Emergency Medicine	<input type="checkbox"/>	<input type="checkbox"/>
<b>Emergency Medicine</b>		
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Undersea and Hyperbaric Medicine	<input type="checkbox"/>	<input type="checkbox"/>
<b>Family Medicine</b>		
Family Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Adolescent Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Hospice and Palliative Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>
<b>Internal Medicine</b>		
Internal Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Adolescent Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Advanced Heart Failure and Transplant Cardiology	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Cardiac Electrophysiology	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Endocrinology, Diabetes & Metabolism	<input type="checkbox"/>	<input type="checkbox"/>
Gastroenterology	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Hematology	<input type="checkbox"/>	<input type="checkbox"/>
Hospice and Palliative Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>
Interventional Cardiology	<input type="checkbox"/>	<input type="checkbox"/>
Medical Oncology	<input type="checkbox"/>	<input type="checkbox"/>
Nephrology	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatology	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Transplant Hepatology	<input type="checkbox"/>	<input type="checkbox"/>
<b>Medical Genetics</b>		
Clinical Biochemical Genetics	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Cytogenetics	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Genetics (MD)	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Molecular Genetics	<input type="checkbox"/>	<input type="checkbox"/>
Medical Biochemical Genetics	<input type="checkbox"/>	<input type="checkbox"/>
Molecular Genetic Pathology	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological Surgery</b>		
Neurological Surgery	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nuclear Medicine</b>		
Nuclear Medicine	<input type="checkbox"/>	<input type="checkbox"/>
<b>Obstetrics &amp; Gynecology</b>		
Obstetrics & Gynecology	<input type="checkbox"/>	<input type="checkbox"/>



	Consultation	Procedures
<b>Obstetrics &amp; Gynecology</b>		
Critical Care Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Hospice and Palliative Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Maternal & Fetal Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Reproductive Endocrinology/Infertility	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ophthalmology</b>		
Ophthalmology	<input type="checkbox"/>	<input type="checkbox"/>
<b>Orthopaedic Surgery</b>		
Orthopaedic Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Orthopaedic Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Surgery of the Hand	<input type="checkbox"/>	<input type="checkbox"/>
Podiatry Medicine	<input type="checkbox"/>	<input type="checkbox"/>
<b>Otolaryngology</b>		
Otolaryngology	<input type="checkbox"/>	<input type="checkbox"/>
Neurotology	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric Otolaryngology	<input type="checkbox"/>	<input type="checkbox"/>
Plastic Surgery Within the Head and Neck	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Medicine	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pathology</b>		
Pathology	<input type="checkbox"/>	<input type="checkbox"/>
Anatomic Pathology & Clinical Pathology	<input type="checkbox"/>	<input type="checkbox"/>
Pathology - Anatomic	<input type="checkbox"/>	<input type="checkbox"/>
Pathology - Clinical	<input type="checkbox"/>	<input type="checkbox"/>
Blood Banking/Transfusion Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Cytopathology	<input type="checkbox"/>	<input type="checkbox"/>
Dermatopathology	<input type="checkbox"/>	<input type="checkbox"/>
Neuropathology	<input type="checkbox"/>	<input type="checkbox"/>
Pathology - Chemical	<input type="checkbox"/>	<input type="checkbox"/>
Pathology - Forensic	<input type="checkbox"/>	<input type="checkbox"/>
Pathology - Hematology	<input type="checkbox"/>	<input type="checkbox"/>
Pathology - Medical Microbiology	<input type="checkbox"/>	<input type="checkbox"/>
Pathology - Molecular Genetic	<input type="checkbox"/>	<input type="checkbox"/>
Pathology - Paediatric	<input type="checkbox"/>	<input type="checkbox"/>
<b>Paediatrics</b>		
Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>
Adolescent Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Child Abuse Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>
Developmental-Behavioral Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>
Hospice and Palliative Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Medical Toxicology	<input type="checkbox"/>	<input type="checkbox"/>
Neonatal-Perinatal Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Neurodevelopmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric Cardiology	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric Critical Care Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric Emergency Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric Endocrinology	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric Gastroenterology	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric Hematology-Oncology	<input type="checkbox"/>	<input type="checkbox"/>







	Consultation	Procedures
<b>Radiology</b>		
Paediatric Radiology	<input type="checkbox"/>	<input type="checkbox"/>
Vascular and Interventional Radiology	<input type="checkbox"/>	<input type="checkbox"/>
<b>Surgery</b>		
General Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Hospice and Palliative Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Surgery of the Hand	<input type="checkbox"/>	<input type="checkbox"/>
Surgical Critical Care	<input type="checkbox"/>	<input type="checkbox"/>
<b>Thoracic Surgery</b>		
Thoracic Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Cardiac Surgery	<input type="checkbox"/>	<input type="checkbox"/>
<b>Urology</b>		
Urology	<input type="checkbox"/>	<input type="checkbox"/>
Paediatric Urology	<input type="checkbox"/>	<input type="checkbox"/>
<b>Medical/Dental Specialties - Others</b>		
a.	<input type="checkbox"/>	<input type="checkbox"/>
b.	<input type="checkbox"/>	<input type="checkbox"/>
c.	<input type="checkbox"/>	<input type="checkbox"/>
d.	<input type="checkbox"/>	<input type="checkbox"/>

<b>Clinical Support Services</b>		
Audiology	<input type="checkbox"/>	
Cosmetology/Aesthetics	<input type="checkbox"/>	
Cancer Immunotherapy	<input type="checkbox"/>	
Cardiac Rehabilitation	<input type="checkbox"/>	
Cardiac Diagnostics	<input type="checkbox"/>	
Counseling	<input type="checkbox"/>	
Dental Laboratory	<input type="checkbox"/>	
Dialysis	<input type="checkbox"/>	
Endoscopy (Gastroscopy and/or Colonoscopy)	<input type="checkbox"/>	
Internal Pharmacy (Non-Retail)	<input type="checkbox"/>	
Internal Laboratory (Non-Retail)	<input type="checkbox"/>	
Laser Therapy	<input type="checkbox"/>	
Medical Physics	<input type="checkbox"/>	
Neurological Rehabilitation	<input type="checkbox"/>	
Neurological Diagnostics	<input type="checkbox"/>	
Nuclear Radiology Imaging	<input type="checkbox"/>	
Nutrition	<input type="checkbox"/>	
Ophthalmic Imaging	<input type="checkbox"/>	
Optometry	<input type="checkbox"/>	
Orthotics & Prosthetics	<input type="checkbox"/>	
Physical Therapy	<input type="checkbox"/>	
Podiatry	<input type="checkbox"/>	
Radiology & Medical Imaging	<input type="checkbox"/>	
Respiratory Therapy	<input type="checkbox"/>	
Regenerative Medicine Therapy	<input type="checkbox"/>	
Speech Language Therapy	<input type="checkbox"/>	
Sleep Medicine Technology	<input type="checkbox"/>	
Ultrasonography	<input type="checkbox"/>	
Occupational Health Therapy	<input type="checkbox"/>	



### Clinical Support Services

Pulmonary Function Technology	<input type="checkbox"/>	
Psychology	<input type="checkbox"/>	
Behaviour consultation and assessment	<input type="checkbox"/>	
Clinical Support Services - Other 1	<input type="checkbox"/>	
Clinical Support Services - Other 2	<input type="checkbox"/>	
Clinical Support Services - Other 3	<input type="checkbox"/>	

### Complementary & Alternative Medicine (CAM)

Ayurveda	<input type="checkbox"/>	
Acupuncture	<input type="checkbox"/>	
Cupping	<input type="checkbox"/>	
Chiropractic	<input type="checkbox"/>	
Guided Imagery	<input type="checkbox"/>	
Homeopathy	<input type="checkbox"/>	
Naturopathy	<input type="checkbox"/>	
Naturopathy	<input type="checkbox"/>	
Osteopathy	<input type="checkbox"/>	
Pilates	<input type="checkbox"/>	
Tai Chi	<input type="checkbox"/>	
Therapeutic Massage	<input type="checkbox"/>	
Traditional Chinese Medicine	<input type="checkbox"/>	
Unani Medicine / Eastern Medicine	<input type="checkbox"/>	
Yoga	<input type="checkbox"/>	
CAM - Others 1	<input type="checkbox"/>	
CAM - Others 2	<input type="checkbox"/>	
CAM - Others 3	<input type="checkbox"/>	

### Laboratory Services

Antenatal Screening Test	<input type="checkbox"/>	
Assisted Reproductive Technology (ART)	<input type="checkbox"/>	
Blood Banking	<input type="checkbox"/>	
Clinical Biochemistry	<input type="checkbox"/>	
Hematology	<input type="checkbox"/>	
Histopathology & Cytology	<input type="checkbox"/>	
Hormonal Assays	<input type="checkbox"/>	
Immunology	<input type="checkbox"/>	
Mycology	<input type="checkbox"/>	
Virology	<input type="checkbox"/>	
Molecular Biology	<input type="checkbox"/>	
Parasitology	<input type="checkbox"/>	
Serology	<input type="checkbox"/>	
Toxicology	<input type="checkbox"/>	
Microbiology	<input type="checkbox"/>	
Lab - Others	<input type="checkbox"/>	
Cytogenetics	<input type="checkbox"/>	
Analytical Chemistry	<input type="checkbox"/>	







### Medical Equipment

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

Equipment	Quantity
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, Full Body	
Scanning Systems, Gamma Camera	
Scanning Systems, General Purpose	
Scanning Systems, Magnetic Resonance Imaging	
Scanning Systems, Positron Emission Tomography	
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

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

**Physicians**


**Nurses**


**Allied Health**


**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**

<input type="checkbox"/>	Business Plan (please request template from CPQ/DHCC)
<input type="checkbox"/>	CV's of Management Team
<input type="checkbox"/>	Passport Copies (refer to sections for Applicant particulars)
<input type="checkbox"/>	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



### Application - Notes

- Note FZ-LLC applicants are restricted from opening a branch within 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 Commercial Licenses are issued for a maximum of 5 selected specialities only unless provisional approval is provided by 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:
- \* Obtain satisfactory levels of compliance to the CPQ Outpatient Clinical Quality Standards 2nd Edition, and participate in all mandatory post operating assessment surveys and other 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

### 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.

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Signature

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Date