



FOR OFFICE USE ONLY

Application No:

APPLICATION MODIFICATION SHEET

1. TYPE OF PRACTICE

2.. FACILITY NAME

3. DATE

4. PROPOSED CHANGES

Please specify the changes to the services offered at or by the facility

Please specify the changes to the GFA of the facility

Please specify the changes to major medical equipment



Please specify any other changes to the facility

5. 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 I understand that approval of the license is dependent on satisfactory compliance with the relevant CPQ/DHCC requirements.

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

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 this requirement.

I understand that CPQ will contact me if additional information is required to complete my application.

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

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

Signature

Date

NOTE: For any changes in Form 1 (e.g., proposed service, area, equipment, or other), please use the attached **Application Modification Sheet**.

Please send the completed form to:

Sales and Leasing Department
Dubai Healthcare City
P.O. Box 66566
Dubai, United Arab Emirates