

<b>For Office Use Only</b>
ID:
Submitted On:

<b>Application for Provisional Operator's Permit</b>
All fields marked with * in the application form are mandatory fields. CPQ will not accept any application which does not have these mandatory fields completed

<b>Inpatient Clinical Provisional Permit - Category of Facility</b>	
Type of Clinical Facility - Inpatient	
<input type="checkbox"/>	General Hospital
<input type="checkbox"/>	Speciality Hospital
<input type="checkbox"/>	Rehabilitation Center
<input type="checkbox"/>	Geriatric Center/Nursing Home
<input type="checkbox"/>	Hospice Care Center
<input type="checkbox"/>	Other Inpatient Center _____

<b>Particulars of Applicant</b> (owner of proposed facility and/or commercial license main shareholder)		
Name (as shown in the passport (include title))*		
Address *		Zip Code
P.O. Box *	City *	Country *
Landline *	Fax *	Mobile *
Email *		

<b>Particulars of Proposed Facility Operator</b> (if applicable, facility managing director/company)		
Name (as shown in the passport (include title))*		
Address *		Zip Code
P.O. Box *	City *	Country *
Landline *	Fax *	Mobile *
Email *		

Note: if this is different than the applicant, kindly include a profile of the operator including experience and services provided



Particulars of Assigned Contact Person (preferred contact if different from applicant)		
Name (as shown in the passport (include title))*		
Address *		Zip Code
P.O. Box *	City *	Country *
Landline *	Fax *	Mobile *
Email *		

Particulars of Premises	
Proposed Operational Name (as applicable to commercial license operational name) *	
Proposed Location (including plot and unit number) *	Proposed Space (in sqft) *

Medical Services *		
kindly note that the following services are also professional licensing general or subspecialty certificates		
Kindly fill-in corresponding on-site service	Planned Services	Number of assigned beds
<b>Allergy &amp; Immunology</b>		
Allergy & Immunology	<input type="checkbox"/>	-----
<b>Anesthesiology</b>		
General Anesthesiology	<input type="checkbox"/>	-----
Critical Care Medicine	<input type="checkbox"/>	-----
Hospice and Palliative Medicine	<input type="checkbox"/>	-----
Pain Medicine	<input type="checkbox"/>	-----
<b>Colon &amp; Rectal Surgery</b>		
Colon & Rectal Surgery	<input type="checkbox"/>	-----
<b>Dentistry</b>		
General Dentistry	<input type="checkbox"/>	-----
Dental Public Health	<input type="checkbox"/>	-----
Endodontics	<input type="checkbox"/>	-----
Oral & Maxillofacial Pathology	<input type="checkbox"/>	-----
Oral & Maxillofacial Radiology	<input type="checkbox"/>	-----
Oral & Maxillofacial Surgery	<input type="checkbox"/>	-----
Orthodontics & Dentofacial Orthopedics	<input type="checkbox"/>	-----
Pediatric Dentistry	<input type="checkbox"/>	-----
Periodontics	<input type="checkbox"/>	-----
Prosthodontics	<input type="checkbox"/>	-----



Medical Services *		
kindly note that the following services are also professional licensing general or subspecialty certificates		
Kindly fill-in corresponding on-site service	Planned Services	Number of assigned beds
<b>Dermatology</b>		
General Dermatology	<input type="checkbox"/>	-----
Clinical & Laboratory Dermatological Immunology	<input type="checkbox"/>	-----
Dermatopathology	<input type="checkbox"/>	-----
Pediatric Dermatology	<input type="checkbox"/>	-----
<b>Emergency Medicine</b>		
General Emergency Medicine	<input type="checkbox"/>	-----
Hospice and Palliative Medicine	<input type="checkbox"/>	-----
Medical Toxicology	<input type="checkbox"/>	-----
Pediatric Emergency Medicine	<input type="checkbox"/>	-----
Sports Medicine	<input type="checkbox"/>	-----
Undersea and Hyperbaric Medicine	<input type="checkbox"/>	-----
<b>Family Medicine</b>		
General Family Medicine	<input type="checkbox"/>	-----
Adolescent Medicine	<input type="checkbox"/>	-----
Geriatric Medicine	<input type="checkbox"/>	-----
Hospice and Palliative Medicine	<input type="checkbox"/>	-----
Sleep Medicine	<input type="checkbox"/>	-----
Sports Medicine	<input type="checkbox"/>	-----
<b>General Medicine</b>		
General Medicine	<input type="checkbox"/>	-----
<b>Internal Medicine</b>		
General Internal Medicine	<input type="checkbox"/>	-----
Adolescent Medicine	<input type="checkbox"/>	-----
Cardiovascular Disease	<input type="checkbox"/>	-----
Clinical Cardiac Electrophysiology	<input type="checkbox"/>	-----
Critical Care Medicine	<input type="checkbox"/>	-----
Endocrinology, Diabetes & Metabolism	<input type="checkbox"/>	-----
Gastroenterology	<input type="checkbox"/>	-----
Geriatric Medicine	<input type="checkbox"/>	-----
Hematology	<input type="checkbox"/>	-----
Hospice and Palliative Medicine	<input type="checkbox"/>	-----
Infectious Disease	<input type="checkbox"/>	-----
Interventional Cardiology	<input type="checkbox"/>	-----
Medical Oncology	<input type="checkbox"/>	-----
Nephrology	<input type="checkbox"/>	-----
Pulmonary Disease	<input type="checkbox"/>	-----
Rheumatology	<input type="checkbox"/>	-----
Sleep Medicine	<input type="checkbox"/>	-----
Sports Medicine	<input type="checkbox"/>	-----
Transplant Hepatology	<input type="checkbox"/>	-----
<b>Medical Genetics</b>		
Clinical Biochemical Genetics	<input type="checkbox"/>	-----
Clinical Cytogenetics	<input type="checkbox"/>	-----
Clinic Genetics (MD)	<input type="checkbox"/>	-----
Clinical Molecular Genetics	<input type="checkbox"/>	-----
PhD Medical Genetics	<input type="checkbox"/>	-----



Medical Services *		
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Kindly fill-in corresponding on-site service	Planned Services	Number of assigned beds
<b>Medical Genetics Cont</b>		
Medical Biochemical Genetics	<input type="checkbox"/>	-----
Molecular Genetic Pathology	<input type="checkbox"/>	-----
<b>Neurological Surgery</b>		
Neurological Surgery	<input type="checkbox"/>	-----
<b>Nuclear Medicine</b>		
Nuclear Medicine	<input type="checkbox"/>	-----
<b>Obstetrics &amp; Gynecology</b>		
General Obstetrics & Gynecology	<input type="checkbox"/>	-----
Critical Care Medicine	<input type="checkbox"/>	-----
Gynecology Oncology	<input type="checkbox"/>	-----
Hospice and Palliative Medicine	<input type="checkbox"/>	-----
Maternal & Fetal Medicine	<input type="checkbox"/>	-----
Reproductive Endocrinology/ Infertility excluding IVF on-site	<input type="checkbox"/>	-----
<b>Ophthalmology</b>		
General Ophthalmology	<input type="checkbox"/>	-----
<b>Orthopedic Surgery</b>		
Orthopedic Surgery	<input type="checkbox"/>	-----
Orthopedic Sports Medicine	<input type="checkbox"/>	-----
Surgery of the Hand	<input type="checkbox"/>	-----
<b>Otolaryngology</b>		
General Otolaryngology	<input type="checkbox"/>	-----
Neurotology	<input type="checkbox"/>	-----
Pediatric Otolaryngology	<input type="checkbox"/>	-----
Plastic Surgery Within the Head and Neck	<input type="checkbox"/>	-----
Sleep Medicine	<input type="checkbox"/>	-----
<b>Pathology</b>		
Anatomic Pathology & Clinical Pathology	<input type="checkbox"/>	-----
Pathology - Anatomic	<input type="checkbox"/>	-----
Pathology - Clinical	<input type="checkbox"/>	-----
Blood Banking/ Transfusion Medicine	<input type="checkbox"/>	-----
Chemical Pathology	<input type="checkbox"/>	-----
Cytopathology	<input type="checkbox"/>	-----
Dermatopathology	<input type="checkbox"/>	-----
Forensic Pathology	<input type="checkbox"/>	-----
Hematology	<input type="checkbox"/>	-----
Medical Microbiology	<input type="checkbox"/>	-----
Molecular Genetic Pathology	<input type="checkbox"/>	-----
Neuropathology	<input type="checkbox"/>	-----
Pathology	<input type="checkbox"/>	-----
Pediatric Pathology	<input type="checkbox"/>	-----
<b>Pediatrics</b>		
General Pediatrics	<input type="checkbox"/>	-----
Adolescent Medicine	<input type="checkbox"/>	-----
Child Abuse Pediatrics	<input type="checkbox"/>	-----
Developmental-Behavioral Pediatrics	<input type="checkbox"/>	-----
Hospice and Palliative Medicine	<input type="checkbox"/>	-----

Medical Services *		
kindly note that the following services are also professional licensing general or subspecialty certificates		
Kindly fill-in corresponding on-site service	Planned Services	Number of assigned beds
<b>Pediatrics</b>		
Medical Toxicology	<input type="checkbox"/>	-----
Neonatal-Perinatal Medicine	<input type="checkbox"/>	-----
Neurodevelopmental Disabilities	<input type="checkbox"/>	-----
Pediatric Cardiology	<input type="checkbox"/>	-----
Pediatric Critical Care Medicine	<input type="checkbox"/>	-----
Pediatric Emergency Medicine	<input type="checkbox"/>	-----
Pediatric Endocrinology	<input type="checkbox"/>	-----
Pediatric Gastroenterology	<input type="checkbox"/>	-----
Pediatric Hematology-Oncology	<input type="checkbox"/>	-----
Pediatric Infectious Diseases	<input type="checkbox"/>	-----
Pediatric Nephrology	<input type="checkbox"/>	-----
Pediatric Pulmonology	<input type="checkbox"/>	-----
Pediatric Rheumatology	<input type="checkbox"/>	-----
Pediatric Transplant Hepatology	<input type="checkbox"/>	-----
Sleep Medicine	<input type="checkbox"/>	-----
Sports Medicine	<input type="checkbox"/>	-----
<b>Physical Medicine &amp; Rehabilitation</b>		
General Physical Medicine & Rehabilitation	<input type="checkbox"/>	-----
Hospice and Palliative Medicine	<input type="checkbox"/>	-----
Neuromuscular Medicine	<input type="checkbox"/>	-----
Pain Medicine	<input type="checkbox"/>	-----
Pediatric Rehabilitation Medicine	<input type="checkbox"/>	-----
Spinal Cord Injury Medicine	<input type="checkbox"/>	-----
Sports Medicine	<input type="checkbox"/>	-----
<b>Plastic Surgery</b>		
General Plastic Surgery	<input type="checkbox"/>	-----
Plastic Surgery Within the Head and Neck	<input type="checkbox"/>	-----
Surgery of the Hand	<input type="checkbox"/>	-----
<b>Preventive Medicine</b>		
Aerospace Medicine	<input type="checkbox"/>	-----
Occupational Medicine	<input type="checkbox"/>	-----
Public Health and General Preventive Medicine	<input type="checkbox"/>	-----
Medical Toxicology	<input type="checkbox"/>	-----
Undersea & Hyperbaric Medicine	<input type="checkbox"/>	-----
<b>Psychiatry and Neurology</b>		
General Psychiatry	<input type="checkbox"/>	-----
General Neurology	<input type="checkbox"/>	-----
Neurology with Special Qualifications in Child Neurology	<input type="checkbox"/>	-----
Addiction Psychiatry	<input type="checkbox"/>	-----
Child and Adolescent Psychiatry	<input type="checkbox"/>	-----
Clinical Neurophysiology	<input type="checkbox"/>	-----
Forensic Psychiatry	<input type="checkbox"/>	-----
Geriatric Psychiatry	<input type="checkbox"/>	-----
Hospice and Palliative Medicine	<input type="checkbox"/>	-----
Neurodevelopmental Disabilities	<input type="checkbox"/>	-----
Neuromuscular Medicine	<input type="checkbox"/>	-----

Medical Services *		
kindly note that the following services are also professional licensing general or subspecialty certificates		
Kindly fill-in corresponding on-site service	Planned Services	Number of assigned beds
<b>Psychiatry and Neurology Cont</b>		
Sleep Medicine	<input type="checkbox"/>	-----
Vascular Neurology	<input type="checkbox"/>	-----
<b>Radiology</b>		
General Diagnostic Radiology	<input type="checkbox"/>	-----
Radiation Oncology	<input type="checkbox"/>	-----
Radiologic Physics	<input type="checkbox"/>	-----
Hospice & Palliative Medicine	<input type="checkbox"/>	-----
Nuclear Radiology	<input type="checkbox"/>	-----
Neuroradiology	<input type="checkbox"/>	-----
Pediatric Radiology	<input type="checkbox"/>	-----
Vascular and Interventional Radiology	<input type="checkbox"/>	-----
<b>Surgery</b>		
General Surgery	<input type="checkbox"/>	-----
Vascular Surgery	<input type="checkbox"/>	-----
Hospice & Palliative Medicine	<input type="checkbox"/>	-----
Pediatric Surgery	<input type="checkbox"/>	-----
Surgery of the Hand	<input type="checkbox"/>	-----
Surgical Critical Care	<input type="checkbox"/>	-----
<b>Thoracic Surgery</b>		
Thoracic Surgery	<input type="checkbox"/>	-----
Congenital Cardiac Surgery	<input type="checkbox"/>	-----
<b>Urology</b>		
General Urology	<input type="checkbox"/>	-----
Pediatric Urology	<input type="checkbox"/>	-----
<b>Others</b>		
a.-----	<input type="checkbox"/>	-----
b.-----	<input type="checkbox"/>	-----
c.-----	<input type="checkbox"/>	-----
d.-----	<input type="checkbox"/>	-----

TOTAL NUMBER OF BEDS -----  
 TOTAL NUMBER OF OPERATING THEATRES -----  
 TOTAL NUMBER OF ICU BEDS -----  
 TOTAL NUMBER OF CCU BEDS -----  
 TOTAL NUMBER OF NICU COTS -----

kindly note that if procedures are performed on-site, they will be dependent on professional licensing and facility classification.



Clinical Support Service	
<b>Kindly fill-in corresponding on-site service</b>	
<input type="checkbox"/> Cardiac Rehabilitation	<input type="checkbox"/> Optometry
<input type="checkbox"/> Counseling/Social Work	<input type="checkbox"/> Orthotics & Prosthetics
<input type="checkbox"/> Dental Laboratory	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Internal Pharmacy	<input type="checkbox"/> Radiology
<input type="checkbox"/> Nutrition	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Audiology	<input type="checkbox"/> Speech Language Therapy
<input type="checkbox"/> Others:	
a. ....	
b. ....	
c. ....	

Complementary & Alternative Medicine	
<b>Kindly fill-in corresponding on-site service</b>	
kindly note that the following services are also professional licensing specialties.	
<input type="checkbox"/> Ayurveda	<input type="checkbox"/> Pilates
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Tai Chi
<input type="checkbox"/> Guided Imagery	<input type="checkbox"/> Therapeutic Massage
<input type="checkbox"/> Homeopathy	<input type="checkbox"/> Traditional Chinese Medicine
<input type="checkbox"/> Naturopathy	<input type="checkbox"/> Unani Medicine/ Eastern Medicine
<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Yoga
<input type="checkbox"/> Others:	
a. ....	
b. ....	
c. ....	

Laboratory Services	
<b>Kindly fill-in corresponding on-site service</b>	
<input type="checkbox"/> Clinical Biochemistry	<input type="checkbox"/> Microbiology
<input type="checkbox"/> Hematology	<input type="checkbox"/> Mycology
<input type="checkbox"/> Histopathology & Cytology	<input type="checkbox"/> Virology
<input type="checkbox"/> Hormonal Assays	<input type="checkbox"/> Molecular Biology
<input type="checkbox"/> Immunology	<input type="checkbox"/> Parasitology
<input type="checkbox"/> Others	<input type="checkbox"/> Serology
	<input type="checkbox"/> Toxicology
a. ....	
b. ....	

Equipment		Quantity
Kindly fill-in corresponding on-site equipment		
<b>Medical Equipment</b>		
<input type="checkbox"/>	Densitometers, Bone	-----
<input type="checkbox"/>	Digital Imaging Systems, Angiographic/Cardiovascular	-----
<input type="checkbox"/>	EEG Monitors; Electroencephalograph	-----
<input type="checkbox"/>	Lasers, Carbon Dioxide, Surgical/Dermatologic	-----
<input type="checkbox"/>	Linear Accelerators; Radiotherapy Units	-----
<input type="checkbox"/>	Lithotripters, Extracorporeal	-----
<input type="checkbox"/>	Radiographic Units, Dental; Digital	-----
<input type="checkbox"/>	Radiographic Units, Mammographic	-----
<input type="checkbox"/>	Radiographic/Fluoroscopic Systems, General Purpose	-----
<input type="checkbox"/>	Recorders, Graphic, Evoked-Potential; Electromyographs; Electronystagmographs	-----
<input type="checkbox"/>	Scanning Systems, Cardiac; Intravascular	-----
<input type="checkbox"/>	Scanning Systems, Computed Tomography, Full Body	-----
<input type="checkbox"/>	Scanning Systems, Gamma Camera	-----
<input type="checkbox"/>	Scanning Systems, General Purpose	-----
<input type="checkbox"/>	Scanning Systems, Magnetic Resonance Imaging	-----
<input type="checkbox"/>	Scanning Systems, Positron Emission Tomography	-----
<input type="checkbox"/>	Sterilizing Units, Steam Bulck / Tabletop	-----
<input type="checkbox"/>	Video Endoscopy System	-----
<input type="checkbox"/>	Washer/Decontaminators	-----
<input type="checkbox"/>	Others	-----
	a.-----	-----
	b.-----	-----
	c.-----	-----

List of Planned Professionals
Kindly list all professionals planned for the facility
<b>Physicians</b>
Kindly list number of physicians per speciality
<b>Nurses</b>
Kindly list number of nurses per qualification
<b>Allied Health Professionals</b>
Kindly list number of allied health professionals per specialty



Current Experience and/ or Operations I	
Facilities (with copy of healthcare operating license from license agency and accreditations if available)	
a. Facility Name	Location
Unique Services	Classification
<b>Name of Licensing Body</b>	<b>Name of Insurance Company</b>
Contact Person	Contact Person
Address *	Address *
Landline *	Landline *
Fax	Fax
Email *	Email *

Current Experience and/or Operations II	
Facilities (with copy of healthcare operating license from license agency and accreditations if available)	
b. Facility Name	Location
Unique Services	Classification
<b>Name of Licensing Body</b>	<b>Name of Insurance Company</b>
Contact Person	Contact Person
Address *	Address *
Landline *	Landline *
Fax	Fax
Email *	Email *

Litigations, Claims and Penalties
Kindly provide us with any documentation and information that relates to any existing or pending litigation, claims, proceedings or investigations by any professional body against any health care professional currently working in your existing entity or entities. Include details of any penalties that have been issued against any existing health care professional or entity.  If there are no litigation matters, claims or penalties to report, please provide a declaration to that effect (attach a separate sheet).

### Education and Research Activities

As a member of the DHCC community, please indicate if you plan to initiate any medical research activities.

Yes  No

If Yes, kindly complete the DHCC Initial Application for Education and Research

- 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.

As a member of the DHCC Community, kindly 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, kindly complete the DHCC Initial Application for Education and Research

- if any education 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.
- As a member of the DHCC community, please note that prior to engaging in any medical Education and/or Research activities, you will be required to complete the provided **DHCC Initial Application for Education and Research** and receive approval from the appropriate council.

### Prior to obtaining a license to operate in DHCC:

- Applicants must submit the Initial Application Form as well as subsequent specialized applications and supporting documents for CPQ review. 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. Details and additional requirements are specified in the DHCC - CPQ Start-Up Handbook.
- If applicable, prior to obtaining the Clinical Operating Permit, applicants must obtain a **Patient Referral Agreement** with a nearby hospital to transfer patients in case of emergency.

### Following admission into 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 or DHCC, which may change from time to time
- All healthcare professionals and TCAM 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 requirements.
- 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 this requirement.
- 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.
- CPQ reserves the right to refuse, at its sole discretion, any application.

-----  
**Signature**

-----  
**Date**

NOTE: For any changes towards the facility (e.g., proposed service, area, equipment, or other), kindly

**Please send the completed form to:**

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