



For Office Use Only
ID:
Submitted On:

Application for Provisional Operator's Permit
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

Type of Permit Applied for:*
Public Health Provisional Permit

Public Health Provisional Permit - Category of Facility	
<input type="checkbox"/>	Aesthetic
<input type="checkbox"/>	Fitness
<input type="checkbox"/>	Non-Medicinal Consumable Products Retail
<input type="checkbox"/>	Retail
<input type="checkbox"/>	Mixed Use
<input type="checkbox"/>	Others

Particulars of Applicant (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 *		

Particulars of Proposed Facility Operator (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)		
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) *

Public Health Facility Classification	
<input type="checkbox"/>	Free Zone Limited Liability Company (FC-LLC)
<input type="checkbox"/>	Branch of a UAE registered Company
<input type="checkbox"/>	Branch of a Foreign registered Company

kindly note if a branch, a copy of the mother company's commercial license must be provided with the IAF

Proposed Services and/ or Products *	
kindly note that the following services are what will be mentioned in the commercial license	
Kindly fill-in corresponding on-site service	
Aesthetic	
Hair Care	<input type="checkbox"/>
Nail Care	<input type="checkbox"/>
Non-Invasive Hair Removal	<input type="checkbox"/>
Non-invasive Weight Loss Treatments	<input type="checkbox"/>
Non-Medicinal Skin Care	<input type="checkbox"/>
Non-Therapeutic Massages	<input type="checkbox"/>
Tanning	<input type="checkbox"/>
Tattoo Services	<input type="checkbox"/>
Fitness	
Gym Services	<input type="checkbox"/>
Non-Medicinal Consumable Products Retail	
Flowers and Plants	<input type="checkbox"/>
Optical Products	<input type="checkbox"/>
Nutritional Supplements	<input type="checkbox"/>
Confectionary	<input type="checkbox"/>



Proposed Services and/ or Products *	
kindly note that the following services are what will be mentioned in the commercial license	
Kindly fill-in corresponding on-site service	
Retail	
Food Establishment	<input type="checkbox"/>
Catering	<input type="checkbox"/>
Mixed Use	
Hotel	<input type="checkbox"/>
Resort	<input type="checkbox"/>
Spa	<input type="checkbox"/>
Childcare Center	<input type="checkbox"/>
Others	
a.	
b.	
c.	
d.	

Equipment	
Kindly provide list of on-site equipment	Quantity
a.	-----
b.	-----
c.	-----
d.	-----
e.	-----
f.	-----
g.	-----

Current Experience and/or Operations		
Facilities (with copy of healthcare operating license from license agency)		
Name	Location	Timeline
a.	-----
b.	-----

Litigations, Claims and Penalties

Please provide us with any documentation and information that relates to any existing or pending litigation, claims, proceedings or investigations by any Body against your existing entity or entities. Include details of any penalties that have been issued against any existing 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 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 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 DHCC review. All organizations are required to agree to certain standards, covenants, and operating procedures. These include adhering to quality and planning requirements and participating in ongoing quality improvement programs. Details and additional requirements are specified in the DHCC - CPQ Start-Up Handbook.

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 licensing requirements. I understand that all professionals at the facility must be licensed by DHCC/CPQ and that the Public Health 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.
- DHCC 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 utilize a new IAF.

Please send the completed form to:

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