SSGMC
SOUTH SUDAN GENERAL MEDICAL COUNCIL

FORM 9A

APPLICATION FOR REGISTRATION OF A PUPLIC MEDICAL INSTITUTION (HEALTHCARE FACILITIES)

YEAR _____

PART 1: BASIC FACILITY INFORMATION

1. Name of Public Health Facility: _____
2. Level of Care: (Tick one)
    - [ ] Primary Health Care Unit (PHCU)
    - [ ] Primary Health Care Centre (PHCC)
    - [ ] County Hospital
    - [ ] State Hospital
    - [ ] Teaching Hospital
    - [ ] National/Specialist Hospital
    - [ ] Other (Specify): _____
3. Physical Address (Location):

County: _____ Payam: _____ Boma: _____

Street/Block No: _____

Town: _____ State: _____

Telephone No. _____ Mobile:_____

Email: _____

4. Administrative Reporting Line:
    - [ ] Ministry of Health (National)
    - [ ] State Ministry of Health

- [ ] County Health Department
- [ ] Other: _____

5. Date of Facility Establishment by Government:

___/___/_____ (DD/MM/YYYY) (Attach establishment circular/letter)

6. Facility In-Charge/Manager:

Name: _____ _____ _____

Title: _____

SSGMC Registration No: _____

Contact: _____ Email: _____

PART 2: GOVERNMENT AUTHORIZATION DOCUMENTS

7. The following documents are MANDATORY for public facilities (attach certified copies):

- [ ] Government Establishment Letter/Circular: Official letter from MOH/State Health Ministry authorizing creation of facility.
- [ ] County/State Health Department Cover Letter: Letter of transmittal from supervising health authority.
- [ ] Facility Staff Establishment Structure: Approved staff positions from Public Service Commission.
- [ ] Annual Work Plan and Budget Approval: Evidence of inclusion in government health sector plan.
- [ ] Integration into Government Systems Confirmation:
  - [ ] Integrated into government payroll system
  - [ ] Receives supplies from Medical Stores
  - [ ] Part of HMIS reporting system

- [ ] Public Asset Registration: Documentation showing facility is registered as government property.

PART 3: FACILITY SERVICE CAPACITY

8. Services Offered: (Tick all applicable)
   - [ ] Outpatient Services
   - [ ] Inpatient Admission
   - [ ] Maternal & Child Health
   - [ ] Immunization (EPI)
   - [ ] Laboratory Services
   - [ ] Pharmacy/Dispensary
   - [ ] Surgical Services
   - [ ] Emergency Services
   - [ ] TB Services
   - [ ] HIV/AIDS Services
   - [ ] Mental Health Services
   - [ ] Other: _____

9. Bed Capacity:

Word/ Type	Male	Female	Total	Remarks
General (OPD)				
Medical				
Surgical				
Maternity				
Pediatrics				
Nursery Incubators				

Isolation				
ICU/CCU				
Total				

PART 4: HUMAN RESOURCES

10. Staff Complement: (Attach detailed roster with names, qualifications, registration numbers, and deployment letters)

Cadre	Approved Establishment (Human Resources)	Currently Deployed	Vacant Positions	Remarks
Specialists				
Medical Doctors				
Dentists				
Pharmacists				
Clinical Officers				
Nurses/Midwives				
Lab Technologists				
Other Allied				
Support Staff				
Total				

PART 5: INFRASTRUCTURE AND EQUIPMENT

11. Physical Infrastructure Status:
    - [ ] Building owned by government
    - [ ] Adequate water supply
    - [ ] Power supply (grid/generator/solar)
    - [ ] Functional incinerator/waste pit
    - [ ] Functional latrines/toilets
    - [ ] Ambulance service available
    - [ ] Mortuary facilities
12. Key Equipment Inventory: (Attach detailed list)
    - [ ] Sterilization equipment functional
    - [ ] Laboratory equipment functional
    - [ ] Surgical sets complete
    - [ ] Delivery kits available
    - [ ] Emergency resuscitation equipment
    - [ ] Refrigerators for vaccines

PART 6: SUPPORTING DOCUMENTS CHECKLIST

13. All public facilities must attach the following:

A. GOVERNMENT DOCUMENTS:

- [ ] Establishment/creation circular
- [ ] Cover letter from supervising health authority
- [ ] Staff deployment lists with letters
- [ ] Proof of integration into government systems (payroll, supply chain)
- [ ] Annual operating budget approval

B. PROFESSIONAL DOCUMENTS:

- - [ ] Staff registration certificates with the respective councils
- - [ ] Current practicing licenses for all professionals
- - [ ] Floor plan of facility

C. HEALTH SYSTEM DOCUMENTS:

- [ ] HMIS reporting records (last 3 months)
- [ ] Medical stores requisition and issue vouchers
- [ ] Waste management plan
- [ ] Infection prevention protocol

D. FACILITY DOCUMENTS:

- [ ] Equipment inventory list
- [ ] Ambulance registration (if applicable)
- [ ] Public health clearance certificate

PART 7: DECLARATIONS

A. Declaration by Facility In-Charge:

I, _____, as the In-Charge of _____, hereby declare that:

1. All information provided in this application is true and correct.
2. This facility operates as part of the Government of South Sudan health system.
3. We comply with all MOH policies, guidelines, and reporting requirements.
4. We shall allow SSGMC officials to inspect the facility at any time.

Signature: _____

Date: _____ **Stamp of Facility**

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B. Authorization by Supervising Health Authority:

This is to certify that the above-named facility is a legitimate government health facility under our supervision and is recommended for registration with SSGMC.

Name of Authority: _____

(County Health Department/State MOH)

Name of the Director: _____

Signature: _____

Date: _____

Official Stamp: _____

For Official Use:

Verified by:

Name: _____ Designation: _____

Signature: _____ Date: _____

Recommended by:

Name: _____ Designation: _____

Signature: _____ Date: _____

Approved ☐ **Not Approved** ☐

Registration/License No: _____

Name: _____ Designation: _____

Signature: _____ Date: _____