SSGMC
SOUTH SUDAN GENERAL MEDICAL COUNCIL

FORM 9B

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

YEAR _____

SECTION A: INSTITUTION/FACILITY DETAILS

1. Name of Healthcare Facility: _____
2. Type of Facility: (Tick one) [ ] Hospital [ ] Specialty Hospital [ ] Medical Centre

   [ ] Medical Complex [ ] Maternity Home [ ] Diagnostic Centre/Laboratory
   [ ] Dental Clinic [ ] Optical Clinic [ ] Physiotherapy/Rehabilitation Centre
   [ ] Clinic [ ] Other (Specify): _____
3. Physical Address (Location):

   County: _____ Payam: _____ Boma: _____

   Street/Block No: _____

   Town: _____ State: _____

   Telephone No. _____ Mobile: _____

   Email: _____
4. Legal Status of Facility Owner:

   [ ] Government (Ministry/State) [ ] Private Individual [ ] Partnership

   [ ] Faith-Based Organization [ ] NGO/INGO [ ] Company (Ltd)

   [ ] Other: _____
5. Full Name of Owner/Proprietor/Institution:

   _____

6. Name of Institution/Facility Manager/Administrator:

   _____ _____ _____

   Qualifications: _____ Phone: _____

   Email: _____

7. Name of the Medical Director/ Chief Executive Officer (CEO)

   _____ _____ _____

   Nationality: _____

   National ID No./ Passport No: _____ Reg. No: _____

   Address: _____

   Town: _____ County: _____ Payam: _____

   Phone No: _____ Mobile: _____

   Email: _____

SECTION B: FACILITY SERVICES AND CAPACITY

8. List all Medical Services Offered:(Tick all that apply)

   [ ] General Outpatient [ ] Inpatient/Admission [ ] Maternal & Child Health (ANC, PNC)

   [ ] Immunization [ ] Laboratory Services [ ] Radiology/Imaging (X-ray, Ultrasound)

   [ ] Pharmacy/Dispensary [ ] Minor Surgery [ ] Major Surgery (Theatre)

   [ ] Dental Services [ ] Eye Care [ ] HIV/AIDS/STI Care [ ] TB Diagnosis/Treatment

   [ ] Emergency Services [ ] Ambulance Services

   [ ] Other (Specify): _____

9. Bed Capacity:

   Total Beds: _____ (Male: _____, Female: _____, Pediatric: _____, Maternity: _____)

   ICU Beds: _____

   Nursery Incubators: _____

Remarks: _____

10. Health Management Information System: _____

    Data follow to MoH: _____

SECTION C: STAFFING COMPLEMENT

11. Number of Key Staff:

    Medical Doctors: _____ Specialists: _____

    Registered Nurses: _____ Midwives: _____

    Laboratory Technologists: _____ Lab Technicians: _____

    Pharmacists: _____ Pharmacy Technicians: _____

    Other Allied Health Professionals: _____

    Support Staff: _____

(Attach a separate list with full names, qualifications, registration numbers with SSGMC/other councils, and roles).

I hereby declare that all professional staff are duly registered and licensed with their respective councils in South Sudan.

Name: _____ Sign: _____ Date: _____

SECTION D: INSTITUTION/FACILITY INFRASTRUCTURE AND EQUIPMENT

12. Brief description of key equipment available (e.g., Autoclave, Microscope, Anesthetic machine, etc.):

    _____

    _____

    (Attach a comprehensive inventory list)

13. Does the facility have:

    a. Reliable Water Source: [ ] Yes [ ] No

    b. Functional Power Supply (Generator/Solar): [ ] Yes [ ] No

c. Sterilization Facilities: [ ] Yes [ ] No

d. Medical Waste Management System: [ ] Yes [ ] No

e. Functional Toilets: [ ] Yes [ ] No

f. Ambulance: [ ] Yes [ ] No

g. Others: _____

SECTION E: SUPPORTING DOCUMENTS CHECKLIST

14. Please attach certified copies of the following documents. Originals must be presented for verification.

a. [ ] Completed Application Form (signed and stamped).

b. [ ] Certificate of Incorporation/Registration of owning entity (from Ministry of Justice/Relief & Rehabilitation Commission for NGOs).

c. [ ] Memorandum & Articles of Association (for Companies/FBOs/NGOs).

d. [ ] Valid Tax Clearance Certificate from National Revenue Authority.

e. [ ] Title Deed or Lease Agreement for the premises (proof of ownership or tenancy of at least 1 years).

f. [ ] Architectural/Floor Plan of the facility.

g. [ ] Public Health Clearance Certificate from relevant State/County Health Department.

h. [ ] Fire Safety Clearance Certificate (if applicable).

i. [ ] Environmental Health Waste Management Plan.

j. [ ] List of all Medical Equipment with proof of ownership/ purchase receipts.

k. [ ] Curriculum Vitae (CVs), Certificates, and valid SSGMC/Professional Council Practice Licenses of all clinical staff.

l. [ ] Application Fee Receipt (Proof of payment to SSGMC account).

SECTION F: DECLARATION AND UNDERTAKING**

I, the undersigned, hereby declare that the information provided in this application and all attached documents are true, complete, and correct to the best of my knowledge. I understand that

any false statement may lead to the rejection of this application or revocation of any license issued.

I undertake to:

a. Comply with all health laws, regulations, and professional standards of South Sudan.

b. Allow authorized officers of the SSGMC to inspect the facility at any reasonable time.

c. Report any significant changes in staff, services, or ownership to the Council promptly.

d. Renew the facility license annually as required.

Signature of Applicant/Owner: _____

Full Name: _____

Title/Position: _____

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: _____