Republic of the Philippines
Department of Health
HEALTH FACILITIES AND SERVICES REGULATORY BUREAU

Form 2 –Rev 2

Name of Health Facility (HF)/Service Provider ______________________________
HF Complete Address: ______________________________
No. & Street Barangay District
____
City/Municipality Province Region
Telephone No. ______________ E-Mail Address ______________ Mobile No. ______________
Head of the Facility/Medical Director: ______________________________
Owner ______________________________
Classification According to:
Ownership: [ ] Government ☐ Province ☐ City ☐ Mun. ☐ DOH-Retained ☐ School Others Specify ______________
[ ] Private ☐ Corporation ☐ Partnership ☐ Single Proprietorship ☐ Cooperative Others Specify ______________
Institutional Character: [ ] Institution-based [ ] Non Institution-based [ ] Free-Standing
Latest LTO/COA/ATO No. ______________ Validity Period from ______________ to ______________
Permit to Construct No. (if applicable) ______________ Date Issued: ______________
Type of Health Facility/Service:

License to Operate:

[ ] Ambulatory Surgical Clinic
[ ] Birthing Home
[ ] Blood Service Facility: ☐ Blood Station (Hosp-based) ☐ Blood Bank ☐ Blood Bank w/ Addt'l. Function ☐ Blood Center
[ ] *Cancer Treatment Facility (CTF)*
a. *Hospital-based CTF:* ☐ *Cancer Specialty Hosp.* ☐ *Cancer Specialty Center in a General Hosp.* ☐ *Cancer Treatment Unit in a General Hosp.*
b. *Non-Hospital-based CTF:* ☐ *Cancer Treatment Satellite* ☐ *Cancer Treatment Clinic*
[ ] Clinical Laboratory
[ ] Dental Laboratory
[ ] Dialysis Clinic
[ ] HIV Testing Laboratory
[ ] Hospital [ ] General ☐ Level 1 ☐ Level 2 ☐ Level 3
[ ] Specialty, Specify ______________________________
[ ] Infirmary
[ ] Primary Care Facility
[ ] Psychiatric Care Facility

[ ] Ambulance Service Provider
Ambulance unit/s approved: No. ______________ Type ______________

Certificate of Accreditation:

[ ] Drug Abuse Treatment and Rehabilitation Center
[ ] Human Stem Cell & Cell-Based or Cellular Therapy
[ ] Kidney Transplant Facility
[ ] Laboratory for Drinking Water Analysis
[ ] *Laboratory for Chemical Water Analysis for Dialysis Water*
[ ] Medical Facility for Overseas Workers and Seafarers
[ ] Newborn Screening Center

CERTIFICATE OF REGISTRATION:

[ ] *Research and Training Clinical Laboratory*

AUTHORITY TO OPERATE (For Free Standing)

[ ] Blood Collection Unit [ ] Blood Station

Type of Application for Change/s (in existing HF) **[Please check [√] appropriate box].**

☐ Increase/Decrease in ABC from ______ to ______
☐ Increase/Decrease in no. of dialysis station from ______ to ______
☐ Change/Additional Equipment (including devices under FDA) Specify ______________________________
____
☐ Change/Additional personnel Specify ______________________________
____
☐ Change in service/s Specify ______________________________
____
☐ Additional service/s Specify ______________________________
____

☐ Change in classification (function, institutional character) Specify ______________________________
☐ Increase/Decrease in ambulance vehicle:
No. of Unit/s from ______ to ______
Type (Specify) from ______ to ______
☐ Hospital downgrading from ______ to ______
☐ Change in Name to ______________________________
____
☐ Others Specify ______________________________
____

Note: Please attach documentary requirements with change/s

Details of Change/s ______________________________
____

______________________________ ______________
Signature over printed name of Head of the Facility/Owner Date

Recommendation: Date__________
☐ For inspection
☐ For submission of documents
☐ For issuance of LTO/COA/COR/ATO
☐ Others Specify ______________________________
____

Recommended by: Approved by:
______________________________ ______________________________
Print Name and Signature