health
Department of Health
FREE STATE PROVINCE

ANNEXURE A

DEPARTMENT OF HEALTH: PROVINCE OF THE FREE STATE

APPLICATION FOR A LICENCE AS A PRIVATE HEALTH ESTABLISHMENT IN TERMS OF THE PRIVATE HEALTH ESTABLISHMENT REGULATIONS OF 2014

THE HEAD OF DEPARTMENT
PO BOX 227
BLOEMFONTEIN
9300

Application is hereby made for a licence for the following private health establishment, details of which are supplied below for the year ending 31 December 20…….

FORM 1

PART A

APPLICATIONS FOR NEW ACUTE AND SUB- ACUTE PRIVATE HEALTH ESTABLISHMENTS
(This section is compulsory and must be completed by all applicants)

1. Name of proposed private health establishment

_____

2. In which area will the private health establishment be built (Town and Suburb)?

_____

3. Has the site already been acquired for the said establishment (Provide Erf Number)?
If a site has not been acquired, full details of the site must be provided to the Department immediately when such a site is acquired.

_____

4. Will there be any other buildings and/or activities on the site other than the proposed private health establishment? If so, provide details.

_____

_____

5. PPP Venture

Is the applicant willing to enter into partnership with the Department for future ventures?

_____

_____

6. List of Shareholders and B-BBEE status

_____

_____

7. Provide applicable details of applicant.

Title: _____ **Initials:** _____ **Surname:**_____

Company: _____ **Trust/CC:** _____

Postal Address: _____

_____

_____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

8. How many other private health establishment licences do you or CC's/Trusts to whom you are affiliated hold nationally? Provide details of other licensed establishment, such as (a) when the licence was granted, (b) when the license expires, (c) composition of licenses e.g. number of beds and theatres etc., (d) location.

_____

_____

_____

(Use separate sheet if necessary)

9. Name, address and contact details of developer.

Title: _____ **Initials:** _____ **Surname:**_____

Company: _____ **Trust/CC:** _____

Postal Address: _____

_____

_____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:**_____

10. Registration number of company or close corporation.

_____

11. Name, address and contact details of service provider (if different to applicant).

Title: _____ **Initials:** _____ **Surname:**_____

Company: _____ **Trust/CC:** _____

Postal Address: _____

_____

_____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:**_____

12. What are the clinical disciplines to be practised in the proposed establishment?

_____

_____

_____

(Use separate sheet if necessary)

FORM 1

PART B

NEW ACUTE PRIVATE HEALTH ESTABLISHMENTS
(This section must only be completed by applicants applying for an Acute Establishment Licenses)

13. Number of beds/treatment stations applied for:

Adult:	I).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____
Maternity:	I).	Obstetrics	_____
	ii).	Babies	_____
Intensive care:	I).	Adult	_____
	ii).	Pediatric	_____
	iii)	Neonatal	_____
High Care:	I).	Adult	_____
	ii).	Pediatric	_____
	iii)	Neonatal	_____
Paediatric	I).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____
Isolation beds:	I).	Adult	_____
	ii).	Pediatric	_____
	iii)	Neonatal	_____
Other Specialized Beds:_____			_____
	_____		_____
	_____		_____
	_____		_____
	_____		_____
TOTAL BEDS APPLIED FOR			_____

14. Number of theatres/treatment rooms applied for:

Minor theatre	_____
Major theatre	_____
Cardiac Theatre	_____
Cardiac Catheterization Laboratory	_____

General Procedure room/s _____

First stage rooms _____

Delivery rooms _____

Other Specialized Units/Suites:
(i.e. Emergency, Endoscopy etc)

Unit Name:

(1) _____ Room Name: _____ Total: _____

(2) _____ Room Name: _____ Total: _____

(3) _____ Room Name: _____ Total: _____

(4) _____ Room Name: _____ Total: _____

(5) _____ Room Name: _____ Total: _____

(6) _____ Room Name: _____ Total: _____

(7) _____ Room Name: _____ Total: _____

(8) _____ Room Name: _____ Total: _____

(9) _____ Room Name: _____ Total: _____

(10) _____ Room Name: _____ Total: _____

15. Number of medical staff to be employed.

	MEDICAL	**DENTAL**	**SPECIALISTS (Specify area of speciality)**
FULL TIME			
PART TIME			

16. Number of nursing staff employed.

	Registered	**Student**	**Enrolled**	**Enrolled pupil**	**Enrolled assistant**	**Enrolled pupil assistant**
FULL TIME						
PART TIME						

17. Other full-time registered staff employed. If any, specify.

_____

_____

_____

_____

18. Other part-time registered staff employed. If any, specify.

_____

_____

_____

_____

19. Do you intend to do nursing training in basic and post basic courses? If yes, specify details of professional organization accreditation (e.g. SANC, HPC etc)

_____

_____

_____

_____

20. Supplementary health services personnel

i).	Administrative personnel	_____
ii).	Management	_____
iii).	General assistant/s	_____
iv).	Maintenance staff	_____

21. Provide a map indicating the drainage area as well as an indication of all other health care establishments (public and private) in the drainage area.

(Use separate sheet and attach as addendum to this application)

22. Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this.

_____

_____

_____

_____

23. Provide detailed reasons in accordance with the criteria as set out in Regulation 14 as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

24. Any other information deemed necessary for this application.

_____

_____

_____

_____

(Use separate sheet if necessary)

I hereby certify that the above particulars are true and correct.

Place _____

Date _____

Office/Position held _____

_____

Signature

FORM 1

PART C

NEW SUB-ACUTE PRIVATE HEALTH ESTABLISHMENTS

(This section must only be completed by applicants applying for a Sub-Acute Establishment License)

25. State what **t**ype of establishment is applied for (i.e. step-down, sub-acute, rehabilitation, long-term, hospice, convalescent)

_____

_____

_____

26. Do you belong to a quality assurance group? If so, provide details.

_____

_____

_____

27. Do you have any managed care or similar arrangement with any health funder/employer?

_____

_____

_____

28. Number of beds/treatment stations applied for:

Adult:	I).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____
Paediatric	I).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____
Other Specialized Beds:	_____		_____
	_____		_____
	_____		_____
	_____		_____
TOTAL BEDS APPLIED FOR			_____

29. Number of treatment rooms applied for:

General Procedure room/s _____

Emergency Room/ Resuscitation Room _____

30. Will you provide any outpatient services?

_____

_____

31. Number of medical staff to be employed.

	MEDICAL	**DENTAL**	**SPECIALISTS (Specify area of speciality)**
FULL TIME			
PART TIME			

32. Number of nursing staff employed

	Registered	**Student**	**Enrolled**	**Enrolled pupil**	**Enrolled assistant**	**Enrolled pupil assistant**
FULL TIME						
PART TIME						

33. Other full-time registered staff employed. If any, specify.

_____

_____

_____

34. Other part-time registered staff employed. If any, specify.

_____

_____

_____

35. Do you intend to do nursing training in basic and post basic courses? If yes, specify details of professional organization accreditation (e.g. SANC, HPC etc.)

_____

_____

_____

36. Supplementary health services personnel

i).	Administrative personnel	_____
ii).	Management	_____
iii).	General assistant/s	_____
iv).	Maintenance staff	_____

37. Provide a map indicating the drainage area as well as an indication of all other health care establishments (public and private) in the drainage area.

(Use separate sheet and attach as addendum to this application)

38. Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this.

_____

_____

_____

39. Provide detailed reasons in accordance with the criteria as set out in Regulation 14 as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

40. Any other information deemed necessary for this application.

_____

_____

_____

(Use separate sheet if necessary)

I hereby certify that the above particulars are true and correct.

Place _____

Date _____

Office/Position held _____

_____

Signature

FORM 2

PART A

APPLICATIONS FOR EXTENSIONS TO EXISTING ACUTE AND SUB-ACUTE PRIVATE HEALTH ESTABLISHMENTS

(To be completed by applicants applying for an extension to their licensed private health establishment)

1. Name of private health establishment

   _____

2. **Physical** address

   _____

   _____

   _____

   _____

3. Erf no: _____

4. **Provide applicable d**etails of applicant.

   Title: _____ **Initials:** _____ **Surname:**_____

   Company: _____ **Trust/CC:** _____

   Postal Address: _____

   _____

   _____

   Office Phone: _____ **Fax:** _____

   E-mail: _____ **Emergency Phone:**_____

5. Registration number of company or close corporation.

   _____

6. Applicable details of service provider

Title: _____ **Initials:** _____ **Surname:**_____

Company: _____ **Trust/CC:** _____

Postal Address: _____

_____

_____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:**_____

FORM 2

PART B

ACUTE PRIVATE HEALTH ESTABLISHMENTS
(This section must only be completed by applicants applying for an extension to an Acute Establishment License)

7. Attach a copy of the existing licenses certificate as an addendum to this application:

41. Number of beds/treatment stations applied for:

Type of beds, theatres, units, rooms	Existing services	New services	Variance
Adult medical beds			
Adult surgical beds			
Obstetric beds			
Adult ICU beds			
Neonatal ICU beds			
Adult High Care beds			
Pediatric beds			
Day beds			
TOTAL NUMBER OF BEDS			
Minor theatres			
Major theatres			
First stage rooms			
Delivery rooms			
Emergency units			
Resuscitation rooms			
Lazer units			
Cath labs			
Haemodialysis unit			
Procedure rooms			

8. Number of theatres/treatment rooms applied for:

Minor theatre _____

Major theatre _____

Cardiac Theatre _____

Cardiac Catheterization Laboratory _____

General Procedure room/s _____

First stage rooms _____

Delivery rooms _____

Other Specialized Units/Suites:
(i.e. Emergency, Endoscopy etc.)

Unit Name:

(1) _____ Room Name: _____ Total: _____

(2) _____ Room Name: _____ Total: _____

(3) _____ Room Name: _____ Total: _____

(4) _____ Room Name: _____ Total: _____

(5) _____ Room Name: _____ Total: _____

(6) _____ Room Name: _____ Total: _____

(7) _____ Room Name: _____ Total: _____

(8) _____ Room Name: _____ Total: _____

(9) _____ Room Name: _____ Total: _____

(10) _____ Room Name: _____ Total: _____

9. Provide detailed reasons in accordance with the criteria as set out in Regulation 14 as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

10. Have there been any structural and/or functional changes in patient accommodation during the current year?

(Use separate sheet if required and attach as addendum to this application)

_____

_____

11. Number of nursing staff employed at the date of application.

	Registered	**Student**	**Enrolled**	**Enrolled pupil**	**Enrolled assistant**	**Enrolled pupil assistant**
FULL TIME						
PART TIME						

12. Number of medical practitioners employed at the time of application

	MEDICAL	**DENTAL**	**SPECIALISTS (Specify area of speciality)**
FULL TIME			
PART TIME			

13. Other existing full-time registered staff employed, if any specify.

_____

_____

14. Other part-time registered staff employed, if any specify.

_____

_____

I hereby certify that the above particulars are true and correct.

Place _____

Date _____

Office/Position held _____

_____

Signature

FORM 2

PART C

SUB- ACUTE EXISTING PRIVATE HEALTH ESTABLISHMENTS
(This section must only be completed by applicants applying for extensions to Sub -Acute Establishment Licenses)

15. State what **service you wish to extend** (i.e. step-down, sub-acute, rehabilitation, long-term, hospice, convalescent)

_____

_____

16. Do you belong to a quality assurance group? If so, provide details.

_____

_____

17. Do you have any managed care or similar arrangement with any health funder/employer?

_____

_____

18. Number of beds/treatment stations applied for:

Adult:	I).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____
Paediatric	I).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____
Other Specialized Beds:	_____		_____
	_____		_____
	_____		_____
	_____		_____
	_____		_____
TOTAL BEDS APPLIED FOR			_____

19. Number of treatment rooms applied for:

General Procedure room/s _____

Emergency Room/ Resuscitation Room _____

19. Will you provide any outpatient services?

_____

_____

20. Number of medical staff to be employed.

	MEDICAL	**DENTAL**	**SPECIALISTS (Specify area of speciality)**
FULL TIME			
PART TIME			

22. Number of nursing staff employed

	Registered	**Student**	**Enrolled**	**Enrolled pupil**	**Enrolled assistant**	**Enrolled pupil assistant**
FULL TIME						
PART TIME						

23. Other full-time registered staff employed. If any specify

_____

_____

24. Other part-time registered staff employed. If any specify

_____

_____

25. Do you intend to do nursing training in basic and post basic courses? If yes, specify details of professional organization accreditation (e.g. SANC, HPC etc)

_____

_____

26. Supplementary health services personnel

i). Administrative personnel _____
ii). Management _____
iii). General assistant/s _____
iv). Maintenance staff _____

27. Provide a map indicating the drainage area as well as an indication of all other health care establishments (public and private) in the drainage area.

(Use separate sheet and attach as addendum to this application)

28. Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this.

_____

_____

29. Provide detailed reasons in accordance with the criteria as set out in Regulation 14 as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

30. What was the average bed occupancy rate and average length of stay for the previous calendar year?

_____

_____

31. What proportion (%) of patients were discharged from the establishment in the last calendar year?

i).	Less than one week	_____
ii).	More than three days but less than one week	_____
iii).	One to three months	_____
iv).	More than three months	_____
v).	No potential for discharge	_____

32. What proportion (%) of admissions were re admissions within:

(a)	3 months	_____
(b)	6 months	_____
(c)	1-year	_____

33. What proportion (%) of patients admitted over the last calendar year were:

i).	Post-surgical (requiring traction, drainage, or wound care?)	_____
ii).	Post-medical illness (e.g. stroke) or requiring low-grade medical interventions (rehydration, IV, antibiotics, oxygen)	_____
iii).	Chronically disabled (mental, physical – e.g. Dementia, hemiplegic)	_____
iv).	Terminally ill (end stage)	_____
v).	For respite care	_____
vi).	Other general rehabilitation	_____
vii).	Patients admitted instead of acute hospitalisation for an acute illness, injury or exacerbation of a disease process	_____

viii). Patients requiring nursing care of low intensity who are likely to remain for a long period of time _____

ix). Other _____

34. Of patients discharged over the last calendar year, what proportion (%) were discharged: (not to be filled in by hospices)

i). Directly home _____

ii). Other community-based facility _____

iii). To a hospice _____

(iv) Other _____

35. Number of full-time and part-time nurses at the establishment at the time of application.

Category of staff	No. of personnel	Full-time	Part-time
(a) Professional Nurse			
(b) ENA			
(c) Enrolled nurses			
(d) Care workers			

*Care workers are workers who deliver basic support and assistance and who assist with activities of daily living and who are not registered with the SANC.

36. Does the establishment provide services rendered by other professionals?

Mark F/T, P/T, SESSIONAL

Doctors (specify)	
Physiotherapists	
Occupational therapists	
Speech and hearing therapists	
X-Ray Services (specify)	
Arrangements for a laboratory services for pathology services (specify)	
Medical specialists (e.g. orthopaedic surgeon, psychiatrists)	
Social Worker	
Pharmacist	
Dietician	
Others (specify)	

37. On average how often are your patients assessed?
(Tick the most appropriate category)

Half hourly	
Hourly	
Between 1 and 4 hourly	
Between 4 and 8 hourly	
Between 8 and 24 hourly	
Once daily	
Between once daily and once weekly	
Less than once weekly	

38. Are the following treatments provided at the establishments?

	Y/N
Oral antibiotics on prescription	
Intravenous medication	
Urinary catherisation	
Blood pressure monitoring	
Oxygen supply and suction	
Ambubag	
Electrocardiograph	
Intubation	
Defibrillation	
Naso-gastric feeding	

39. Of your last 100 admissions, what % were referred by:

A private hospital	
A private medical practitioner	
A private practitioner other than a private medical practitioner	
A public hospital	
A residential facility such as an old age home	
A welfare institution other than a residential facility	
A traditional healer	
Directly by the family	
Referred by self	
Case manager (e.g. QA Care)	
Others (specify)	

40. Do you provide any out- patient services?

_____

_____

Place _____

Date _____

Office/Position held _____

_____

Signature

ANNEXURE A

FORM 3

CHECK-LIST OF DOCUMENTS THAT SHOULD BE SUBMITTED WITH THE APPLICATION FORMS

DOCUMENTS	TICKS
Motivational letter	
Proof of payment	
Proof that the applicant has advertised in the relevant local paper the intention to build the private facility	
Proof of community endorsement of the project	
A letter from the Municipality stating that the desired land has been granted and is suitable for the intended business	
Feasibility study	
Business Plan	
Proof of financial viability	
Human resource recruitment plan	
B-BBEE certificate and list of shareholders	
Community Involvement/social responsibility plan	

ANNEXURE A

FORM 4

DEPARTMENT OF HEALTH: PROVINCE OF THE FREE STATE

APPLICATION FOR REGISTRATION AS A PRIVATE HEALTH ESTABLISHMENT IN TERMS OF THE PRIVATE HEALTH ESTABLISHMENT REGULATIONS OF 2014

The Head of Health
Private Bag 227
BLOEMFONTEIN
9300

Application is hereby made for the registration of the following *private hospital / unattached Operating-theatre unit, details of which are supplied below for the year ending 31 December …….

(d) Name of private hospital/unattached operating-theatre unit……...

……

2. Situation of premises (street, locality, town) ……...
……

3. Name and postal address of registered owner of the property (premises) ……
……

4. Name and address of proprietor (in the case of a company or association, its nominee) who will be conducting the *private hospital/unattached operating-theatre unit……..
……

5. Name and address of the medical practitioner or registered nurse and midwife who will be in charge ……

6. If a medical practitioner will be in charge, name and qualifications of the registered nurse and midwife who will be in charge of the nursing services……..
……

7. Name and allocation of beds available for patients (see notes below)……..
……

	General		Maternity		Infectious diseases	Others (specify)	Total
White…….							
Non-white……..							

8. Number of:

(e) Operating theatres……...

(b) Delivery rooms……

9. Changes in the patient accommodation/beds available during the current year, if any (specify) ……

10. Numbers of registered staff *employed at date of application/to be employed at date of new registration applied for:

		Practitioners		Nurses	
		Medical	Dental	Registered	Student
Full-time……	White…….				
	Non-white……				
Part-time……	White……				
	Non-white……				

(f) Number of full-time enrolled nurses *employed at the date of application / to be employed at date of new registration applied for:

		Enrolled Nurses	Enrolled student nurses	Enrolled nursing assistants	Enrolled pupil nursing assistants
Full-time ……	White…….				
	Nonwhite……				

(g) Other full-time registered staff employed (if any) (specify) …….
……..

13. Other part-time registered staff employed (if any) (specify) ……
……

14. If the hospital is recognized by the South African Nursing Council as an approved training school for nurses, midwives or enrolled nurses or enrolled nursing assistants:

(a)

General nurses	Midwives	Enrolled nurses	Enrolled nursing assistants

(b) If the hospital is recognized as an approved training school for one or more of the categories of nursing staff referred to in subsection (a), the following information should also be given:

Category	Number of registration or enrolment certificate issued by the SANC	Date of issue
(i) Student general nurses…….		
(ii) Student midwives……		
(iii) Pupil nurses……		
(iv) Pupil nursing assistants……..		

Registration with the SA Nursing Council (specify):

	Number of original certificate	Date of issue	Annual registration	
			Receipt number	Date

I Other trained staff, excluding person in control:
(i) Registered nurses/midwives:

Name	Qualifications	Number of original certificate	Date of issue	Annual registration	
				Receipt number	Date

(ii) Enrolled nurses ……...

Total…….. ……

(iii) Enrolled nursing assistant……..

Total…….. ……

15. Arrangements for the training and teaching of each of the following categories, as applicable:

(h) Student nurses…..……

(ii) Student midwives…….

(iii) Pupil nurses……..

(iv) Pupil nursing assistants……

I hereby certify that the above particulars are true and correct

Place……

Date……. **……**
Signature of proprietor

N.B.-If available space is insufficient, attached separate schedule.
Notes:

(a) *Words designated by an asterisk to be deleted if not applicable
(b) This form is to be used for the first and every subsequent application for registration.
I Item 7: The numbers of beds, cribs/cots actually available for accommodating patients are to be stated, but these exclude –
• all trolleys;
• all waiting, preparation, first stage and labour room beds and cots in maternity units;
• the recovery trolleys and recovery beds of an operating-theatre unit of a private hospital, but not those of an unattached operating-theatre unit.

ANNEXURE A

FORM 5

CHECK-LIST OF DOCUMENTS THAT SHOULD BE SUBMITTED WITH THE APPLICATION FORMS FOR RENEWAL OF LICENSES

DOCUMENTS	**TICKS**
Proof of payment for renewal of license	
Spreadsheet of monthly bed occupancy and theatre utilization (time) data of previous financial year	
Proof of Registration with relevant statutory bodies for all health care professionals employed by the hospital i.e. nurses, pharmacists and therapists	
Proof of registration with relevant statutory bodies for health care professionals not employed by the hospital i.e. doctors and therapists	
B-BBEE Certificate	
Liability Insurance	