



Republic of the Philippines
Department of Health
Center for Health Development



Region
Address of CHD:
Trunk Line: Direct Line: Fax:
URL: <http://www.doh.gov.ph>; e-mail:

**APPLICATION FORM
CERTIFICATE OF NEED FOR GENERAL HOSPITALS**

Name of Proposed Hospital: _____

Complete Address of Proposed Hospital: _____

Name of Proponent: _____

Address of Proponent: _____

Contact Number: _____

Classification According to:

Ownership:

- Government
- Private

Service Capability:

- Level 1
- Level 2
- Level 3
- Level 4

Total Capital Investment for the Proposed Hospital: ₱ _____

Total Lot Area of the Proposed Site: _____

Proposed Total Bed Capacity: _____

CHECKLIST OF DOCUMENTS:

- Application Form for Certificate of Need for Hospitals
- Certification from Provincial Planning and Development Office that the Proposed Hospital is part of the duly approved Provincial Hospital/Health Care Delivery Plan (if available)

Note: The CHD may ask for additional requirements should there be more than one applicant covering the same catchment area.

Documents Checked by: _____

Amount Paid _____
O.R. Number _____
Date _____

Applicant
Signature above Printed Name
Date _____

Projected Primary and Secondary Catchment Population(P) of the Proposed Hospital		
	Barangay/Municipality/District/Province/Region	Projected Population (5 th year) of Catchment Area
Primary Catchment Area:		
Secondary Catchment Area/s:		
Total Projected Primary and Secondary Catchment Population (P) =		

List of existing hospitals currently managed/operated by the Proponent, if any:							
Name of Existing Hospital/s	Location	ABC*	Category of Hospital	License Number	Validity Period	Date (Year/s) of Operation	Remarks

***ABC – Authorized Bed Capacity**