

**MEDICAL COUNCIL OF ZAMBIA
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**THE MEDICAL AND ALLIED PROFESSIONS ACT, CAP. 297
(Establishment and Registration of Consulting Rooms Rules-1981)**

**APPLICATION FOR REGISTRATION / RENEWAL OF PRIVATE
CONSULTING ROOMS AND HOSPITALS**

Instructions

- (1) Part A of this application shall be filled in by the Proprietor.*
- (2) The Medical Practitioner in charge of the Consulting Room or Hospital, should fill in Part B and C of this Application Form.*
- (3) The application for registration/renewal of registration shall be accompanied by an appropriate fee.*
- (4) Payments can also be made direct into the MCZ Account on special arrangements.*
- (5) Payment for renewal received after the 31st day of October in the year preceding the year for which the renewal is applied for will attract a penalty fee and no Certificate will be issued if the penalty fee has not been paid.*

Note: It is illegal for any person to operate a Private Hospital or Consulting Room without a valid Registration Certificate. (Section 44, CAP 297 of the Laws of Zambia).

PART A

I hereby apply for Registration / renewal of registration of a Consulting Room/Hospital, the particulars whereof are given hereunder:

Name of Consulting Room/Hospital:

Registration No:..... Postal Address:

Plot No: Street:.....

Town:.....

Phone No: Cell phone No:

Email:.....

Owner (s) of Consulting Room/Hospital

Name

Nationality

(a) _____

(b) _____

(c) _____

(d) _____

Date of application:.....

Signature:

PART B – SERVICES

(a) Average No. of monthly out patient first attendance(for those

applying for renewal only)

(b) Type of Institution (Tick whichever is applicable)

- Hospital
- Consulting Room without additional Services
- Consulting Room with additional Services
(i.e. Laboratory, Diagnostic Imaging etc.)

(c) Specialised Consulting Rooms - Optical, Dental, Physiotherapy, Hospice, Ambulance/Emergency Care Services **Delete whichever is not applicable*

(d) Diagnostic Consulting Rooms - Voluntary Counseling and Testing (VCT), Imaging, Laboratory ** Delete whichever is not applicable*

(e) Others (specify)

(f) Details of rooms, facilities and equipment provided

PART C – STAFFING

(i) Medical Practitioner in charge

Surname: Other names:

Registration Certificate No: Date of full Registration:

(ii) Full time Medical Practitioners/Dental Surgeons

Name	MCZ Reg No.
(a) _____	_____
(b) _____	_____
(c) _____	_____
(d) _____	_____

(iii) Part time Medical Practitioners/Dental Surgeons

Name	MCZ Reg No.
(a) _____	_____
(b) _____	_____
(c) _____	_____
(d) _____	_____
(e) _____	_____
(f) _____	_____

(iv) Full time Nursing Staff

Name	GNC Reg No.
(a) _____	_____
(b) _____	_____
(c) _____	_____
(d) _____	_____
(e) _____	_____

(v) Part time Nursing Staff

Name	GNC Reg. No.
(a) _____	_____

- (b) _____
- (c) _____
- (d) _____
- (e) _____
- (f) _____

(vi) Full time Paramedical Practitioners

Name	Profession	MCZ Reg No.
(a) _____	_____	_____
(b) _____	_____	_____
(c) _____	_____	_____
(d) _____	_____	_____

(vii) Part time Paramedical Practitioners

Name	Profession	MCZ Reg No.
(a) _____	_____	_____
(b) _____	_____	_____
(c) _____	_____	_____
(d) _____	_____	_____

(viii) Non-Health Workers

Name	Occupation
(a) _____	_____

(b) _____

(c) _____

(d) _____

(e) _____

I declare that the information I have given above is true and accurate to the best of my knowledge.

Date

Signature