Ministry of Health
Republic of Maldives

Health Protection Agency

Form No.: MOH-HPA/F/25/202-0

Version 1.0

Application Form for Designation as a Pre-Departure Health Assessment (PDHA) Facility

Instructions

Please complete all sections of this form accurately. Incomplete applications may result in delays. Attach all required documents listed in Annex 1.

SECTION 1: FACILITY INFORMATION

Please provide key details about the health facility applying for designation

1.1 Facility Name	
1.2 Facility Address	
1.3 Facility Registration No.	
1.4 Facility Registration Expiry (fill if applicable)	
1.5 Operating License No.	
1.6 Operating License Expiry (fill if applicable)	
1.7 Business Registration Number (fill if private)	
1.8 Business Registration Expiry (fill if applicable)	

1.9 Facility Ownership ☐ **Government** ☐ **Private**

1.10 Governing Ministry or Board Name

1.11 Registration Number

SECTION 2: FACILITY INFRASTRUCTURE

Indicate available facility infrastructure necessary for PDHA operations

☐ **2.1 Consultation Room** ☐ **2.2 X-Ray Room** ☐ **2.3 Treatment Room** ☐ **2.4 Laboratory**

☐ **2.5 Waste Management Area** ☐ **2.6 Vaccination Room** ☐ **2.7 Patient Waiting Area** ☐ **2.8 Sterilisation Room**

☐ **2.9 Toilets** (accessible to persons with special needs)

SECTION 3: MEDICAL STAFF INFORMATION

Provide details of the health professionals involved in PDHA operations. All health professionals must be licensed to practice in the country where the health facility associated with this application is located

#	NAME	DESIGNATION	LICENSE NO.	LICENSING BODY

SECTION 4: RESPONSIBLE PERSON DETAILS

Provide information on the individual responsible for daily PDHA operations

6.1 Full Name (as in ID)	
6.2 Passport/ Other ID No.	
6.3 Nationality	
6.4 Contact Number	
6.5 Email Address	

SECTION 5: DECLARATIONS AND CONSENT

1. I certify that the information provided in this application is true and accurate to the best of my knowledge
2. I agree to comply with all PDHA requirements and standards set forth by the Ministry of Health, Maldives
3. I understand that failure to comply with standards or providing false information may lead to the revocation of designation.
4. I acknowledge the requirement to pay the application fee of USD 2,000 (Two Thousand US Dollars) and the annual renewal fee of USD 1,000.00 (One Thousand US Dollars) upon approval

Signature of Operator	
Date	

For Official Use by the Maldives Ministry of Health Only

Application Received on				
Inspection Date (if applicable)				
Reviewed by				
Comments				
Designation Status		Approved		Rejected
Designation Valid Until				

ANNEX 1: REQUIRED DOCUMENTS CHECKLIST

Failure to submit the following will result in an automatic cancellation of this application

- [ ] **1 Valid Facility Operating License**
- [ ] **2 Facility Floor Plan**
- [ ] **3 Attested Copy of Operator's Passport/ Registration**
- [ ] **4 Comprehensive Services Proposal**
  a. Service hours
  b. Eligible recipients of services
  c. List of medical professionals and staff
  d. Proposed service charges
- [ ] **5 List and Valid Licenses of Medical Staff (attested copies or electronically verifiable documents)**
- [ ] **6 Accreditation Certificates (if applicable)**
- [ ] **7 Evidence of Governing Ministry or Board Registration**
- [ ] **8 Health facility data management policy**