

ALLIED HEALTH PROFESSIONALS COUNCIL

MINISTRY OF HEALTH P.O.BOX 7272, KAMPALA

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Website: www.ahpc.ug

**APPLICATION FOR REGISTRATION OF MEDICAL LABORATORIES**

1. Lab in-charge’s Name: ………………………………………………………………………..
2. Registered Title of the Lab in-charge: .………………………………………………………..
3. Registration Number: ………………………Registration date: ……………………………...
4. Name of Laboratory: ………. ………………………………………………………………...
5. Owner of Laboratory: …………………………………………………………………………
6. Postal Address: …………………………….………………………………………………….
7. Tel No(landline).…………………………………………Mob :……………………………...
8. Locality: ……………………………………..…….….Sub County: ………………………...

Plot No. ……………………………………………….…Street: …………………………….

City/Town/TC: ………………………………………… District: …………………………...

9. Type of Laboratory: (Please Tick)

* Clinical Laboratory/Medical Research Laboratory

10. Category of Laboratory: (Please Tick)

* Laboratory in a Clinic/Health Centre
* Laboratory in Hospital
* Stand Alone/Reference Laboratory

 Date: ……………………Name………………………………………..Signature: …………….

 **Note: Please attach the following documents:**

* Copy of Registration certificate and Current Annual Practicing license for lab in-charge
* Copy of final academic transcript for lab in-charge
* Copy of valid operational license if Lab is under a Clinic/Health Centre or Hospital

 11. Contact the District Laboratory Focal Pearson (DLFP) for inspection and other details

**FOR OFFICIAL USE ONLY**

Recommendation from Office of the Registrar

………………………………………….…………………………………………………………………

Name…………………………………………Signature: …………………. Date: ……………………..