TRADITIONAL AND ALTERNATIVE HEALTH PRACTICE COUNCIL

(Communications to be addressed to THE REGISTRAR)

Tel. 255-022-2120261-7 Ext. 331
Fax: 255-022-2139951

Office of the Registrar
P.O. Box 9083
DAR ES SALAAM
TANZANIA

FORM No. 9

APPLICATION FOR REGISTRATION OF ALTERNATIVE HEALTH FACILITY OWNED BY COMPANY/ORGANIZATION/INSTITUTION

(Under S. 14-16 of the Traditional and Alternative Medicines Act No.23 of 2002, S. 35 of Registration Regulations)

PART I

A: To be filled in quadruplets B: To be used in one area only.

1. Name of Company/Organization/Institution……

   Physical Address……..……

   Postal address……..Telephone……..

   Registration No……..Date of Issue……..

   Issuing Authority……

   Business Licence……TIN NO……..(where applicable)

2: Responsible registered Alternative health Practitioner:

   Surname:…….Other names:……..

   Date of birth……Sex……..

   Registration No……Date of issue…….

3. Residence: Region:……District:……..

   Ward:……Village/Mtaa……..

4. Nationality…… ……

   Postal address:……Telephone…… ……..

5. Type of Alternative Health Facility applied for:……(use √ to indicate)

   (a) Clinic [ ] (b) Dispensary [ ] (c) Health Centre [ ] (d).Hospital [ ]

6. Name of Health Facility/Business……..

   Physical address of the facility …….

An estimate value of alternative medicine shop/store in shillings……

7. Type of alternative medicine practice applying for (use √ to indicate)

[ ] Homoeopath; [ ] Natural path; [ ] Radionic medicine and Osteopath;

[ ] Acupuncture, acupressure and Reiki; [ ] Iridology

12. Type(s) of services (use √ to indicate):

(a) Out patient [ ]

(b) In patient [ ]

I hereby certify that the above particulars are correct to the best of my knowledge.

Signature:…… Date:……..….

PART II
TO BE ENDORSED WITH RECOMMENDATION BY:

(i) OFFICE OF THE DISTRICT, TOWN/MUNICIPAL OR CITY DIRECTOR

By resolution made by the Council Health Management Team held on ……recommends that the above named alternative health facility be registered/the applicant should not be registered for the following reasons:……
……...……
……...……
……...……

Signature:…….. Date:…….

(ii) OFFICE OF THE REGIONAL MEDICAL OFFICER

By resolution made by the Regional Health Management Team recommends that the above named alternative health facility be registered/the applicant should not be registered for the following reasons:……..
……...…
…….……
……...……

Signature:…….. Date:…….

PART III

(FOR OFFICIAL USE ONLY)

DECISION:

This application has been approved/rejected for the following reasons:-

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....

Signature of Registrar **Date**

This form is to be submitted with the following:

1. *Certified copy of registration and practicing license of the responsible alternative health practitioner
2. Three passport size photographs.
3. Letter of recommendation from the Regional Medical Officer of the Region in which s/he is practising
4. A non refundable fee as follows:
    (a) Clinic or Dispensary US Dollars 4,000.00
    (b) Health centre or Hospital US Dollars 6,000.00

Account Number for the Council of foreign currency (USA Dollars)

1014926018 Twiga Bancorp Branch, Samora Avenue

Note:

(a) Documents which are not in English Language must be translated by a recognized authority and attached to the documents of the original language.

(b) The information contained in this application will be used for the purposes of processing your application and will form the basis of your registration records.

(c) All decisions by the Council will be taken in good faith on the basis of the statement made on your application form. If it is discovered that an applicant has made a false statement or has omitted significant information on the application, the Council may withdraw or amend its offer according to the circumstances.

*(d) *Anon-citizen can not be responsible alternative health practitioner of the facility owned by Company/Organization/Institution.*