SOCIAL SECURITY BOARD

National Health Insurance

TENDER APPLICATION FORM

NATIONAL HEALTH INSURANCE

Category of Services: PRIMARY CARE PROVIDER

Name of Applicant: _____

Name of Firm/Clinic: _____

Address of present Firm/Clinic: _____

Email: _____

Applicant's Telephone number: _____

Profession of Applicant: _____

Applicant's Date of Birth: _____

Years of Professional Experience: _____

Nationality: _____

Professional Associations he/she belongs to: _____

_____

Education (Summarize the higher education and other specialized studies and trainings of the applicant, indicating the names of the institutions of higher learning, dates or attendance and degrees obtained).

_____

_____

_____

_____

_____

Working Experience: (Beginning with the current position followed by other posts occupied and years of experience for each post)

1. _____
2. _____
3. _____
4. _____
5. _____

Would the Primary Care Provider Clinic remain at present location, or would you need to relocate?

Remain at the present location _____ Relocate to a new address_____

If there is need to relocate, kindly provide the address:

_____

Any other support services are offered at your present facility?

If Yes, please specify:

____ Pharmacy

____ Laboratory

____ Imaging and Diagnostics

Copy of Business Certificate is to be attached to the application.

Please note: This in no way commits you to involvement in the roll out of NHI. It is an expression of interest only which should be followed by the detail proposal. The guide for the proposal will be provided upon your submission of this application. A technical team will visit your premises to evaluate certain elements such as: qualification of professional staff, adequacy of the facility and availability of basic equipment for the provision of services.

Date: _____ Signature: _____