	Civil Aviation Authority - Sultanate of Oman **Flight Safety Department - Personnel Licensing Section** **MEDICAL INVESTIGATION AND DIAGNOSTIC FACILITY APPLICATION FORM**
A. FACILITY DETAILS:	
1. NAME: (Registered Business Name)	
2. ADDRESS:	
3. EMAIL ADDRESS:	
4. TEL NUMBER:	
5. HEALTH AUTHORITY LICENSE NUMBER AND EXPIRY DATE:	
6. TYPE OF THE MEDICAL FACILITY:	
7. REQUESTING CERTIFICATION APPROVAL FOR:	☐ Initial Approval ☐ Renewal Approval ☐ Re-Location Approval
B. MEDICAL ACCOUNTABLE MANAGER DETAILS:	
1. FULL NAME:	
2. CIVIL ID/ PASSPORT NUMBER:	
3. EMAIL ADDRESS:	
4. MOBILE NUMBER:	
C. LIST OF LICENSED LAB TECHNICIANS AND PATHOLOGISTS WITH HEALTH AUTHORITY LICENSE NUMBERS:	
1.	
2.	
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4.	
D. LIST OF ADMIN STAFF WITH CONTACT DETAILS:	
1.	
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3.	

E. LIST OF ALL AVAILABLE MEDICAL INVESTIGATION AND DIAGNOSTIC EQUIPMENT WITH BRAND NAME:
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F. DOCUMENT REQUIREMENTS:	
Application letter from the facility to CAA	☐
Copy of MOH Medical Facility Approval/ License	☐
Copy of MOH Medical Facility Approval/ License	☐
Copy of the Medical Staff Resume ***(for Initial only)***	☐
Copy of the Valid Health Authority License for the Medical Staff ***(for Initial only)***	☐
Copy of the CME records for the past two years ***(for renewal only)***	☐
Copy of Equipment Calibrations	☐
Copy of Facility Scope of Work	☐
Quality Management System (QMS) Documentation	☐
Copy of Standards Operating Procedure (SOP)	☐
Copy of referral arrangement (s) with other laboratories, advanced imaging centers**, etc**	☐
Copy of Medical Record Policy	☐
Copy of Medical Waste Contract	☐

G. APPLICANT DECLARATION:

☐ **Applicant's declaration and acceptance of the General Conditions and Terms of Payment**

I declare that I have the legal capacity to submit this application to the CAA and that all information provided in this application form is correct and complete.

i. NAME of Accountable Manager:	
ii. SIGNATURE:	
iii. DATE:	
iv. STAMP:	

CAA USE ONLY:

H. MEDICAL ASSESSOR(S) REMARKS AND OBSERVATIONS:

I. MEDICAL ASSESSOR(S) RECOMMENDATION:

1. The Application meets/does not meet the professional qualifications, medical facility requirements, and equipment required for further processing of the Medical Investigation and Diagnostic Facility Designation. (please tick the appropriate block)

MEET	☐	DOES NOT MEET	☐

2.	If the Facility Does Not Meet the requirements for further processing of the Medical Investigation and Diagnostic Facility Designation: Give reason (s):	
J. LEAD MEDICAL ASSESSOR/ INSPECTOR RECOMMENDATION:		
1.	**RECOMMENDATION:**	
2.	i. NAME:	
	ii. SIGNATURE:	
	iii. DATE:	
	iv. STAMP:	

K. APPROV AL OF DIRECTOR OF FLIGHT SAFETY (DFS): *Tick as appropriate:*

1.	**RECOMMENDATION APPROVED**	☐	**RECOMMENDATION NOT APPROVED**	☐
	i. NAME:			
	ii. SIGNATURE:			
	iii. DATE:			
	iv. STAMP:			