Republic of the Philippines
DEPARTMENT OF HEALTH

ORDER OF PAYMENT

ONE STOP-SHOP PRIVATE HOSPITAL

Date: _____ Form OP 01 Revision 9

NAME OF HOSPITAL: _____

ADDRESS: _____

To CASHIER: Please charge the amount of _____ (Php _____) for:

DC2019-0497 dtd 5292019 LTO Cert rHIVda; DC2018-0538 dtd 10182018 -LTO G6PD

Board Regulation No.2, 2019 (DDB)DATRC

DC 2018-0023 dtd 5/29/18 RCP-CL

AO 2016-0029 AnnexE dtd 6/29/2016 Ambulance; AO 2014-0034 dtd. 11/13/2014 (Pharmacy)

AO 2012-0012 dtd. 7/18/2012 hosp

AO 2008-0008 dtd 5/2/2008-BSF; AO 2007-0023 dtd 6/6/07

AO 2007-0023 dtd 6/6/2007-Schedule of Fees OSS Hosp; AO 2007-0001- Schedule of Fees; AO 2019-0004 dtd 4302019 cut-off dates received application

(Please check the appropriate box)

	Initial (New/With Changes) Form 1 & Form 2	Renewal** Form 1	Remarks
Registration Fee (New)	200.00		
Level 1 Hospital	6,500.00	6,000.00	
	w/ 10% disc.	5,400.00	
Level 2 Hospital	8,500.00	7,500.00	renewal-yearly
	w/ 10% disc.	6,750.00	
Level 3 Hospital	10,500.00	8,500.00	
	w/ 10% disc.	7,650.00	
CLINICAL LABORATORY(GENERAL)			renewal-yearly
Secondary	2,500.00	2,000.00	
	w/ 10% disc.	1,800.00	
Tertiary	3,000.00	2,500.00	
	w/ 10% disc.	2,250.00	
G6PD Confirmatory Lab. (Add-on Service)			renewal yearly inlcuded in ClinLab
Remote Collection Permit- ClinLab (P500.00 each remote collection)			
CLINICAL LABORATORY (SPECIAL)	200.00		
Specify type of lab service/s _____			
BLOOD SERVICE FACILITY:			renewal-yearly
BLOOD BANK	5,000.00		
BLOOD BANK with additional function	5,000.00		
BLOOD STATION	1,400.00		
Ambulance Service Provider	5,000.00	5,000.00	renewal-yearly
Ambulance (P1,000.00 per unit)			
AMBULATORY SURGICAL CLINIC	4,000.00	4,000.00	no renewal fee if fully owned by the hospital
	w/ 10% disc.	3,600.00	
DIALYSIS CLINIC	3,000.00	3,000.00	no renewal fee if fully owned by the hospital
	w/ 10% disc.	2,700.00	
DRUG TESTING LABORATORY (screening)	5,000.00	5,000.00	renewal-yearly
DRUG TESTING LABORATORY (confirmatory)	10,000.00	10,000.00	renewal-yearly
CASH BOND (DTL)	20,000.00		

	Initial (New/With Changes) Form 1 & Form 2	Renewal ** Form 1	Remarks
DRUG ABUSE TREATMENT AND REHABILITATION CENTER - RESIDENTIAL	14,000.00	14,000.00	renewal every 3 yrs.
	w/ 10% disc.	12,600.00	
DRUG ABUSE TREATMENT AND REHABILITATION CENTER - NON RESIDENTIAL	6,000.00	6,000.00	renewal every 3 yrs.
	w/ 10% disc.	5,400.00	
DRUG ABUSE TREATMENT AND REHABILITATION CENTER - RESIDENTIAL W/ OUT-PATIENT	15,000.00	15,000.00	renewal every 3 yrs.
	w/ 10% disc.	13,500.00	
CASH BOND (DATRC)	30,000.00		
HUMAN STEMCELL & CELL-BASED OR CELLULAR THERAPY	38,000.00	38,000.00	renewal every 3 yrs.
	w/ 10% disc.	34,200.00	
HIV TESTING LABORATORY			renewal yearly inlcuded in ClinLab
Certified rHIVDA Conf. Lab. (Add-on Service)			renewal yearly
KIDNEY TRANSPLANT FACILITY	38,000.00	38,000.00	renewal-every 3 yrs.
	w/ 10% disc.	34,200.00	
LABORATORY FOR DRINKING WATER ANALYSIS	5,000.00		renewal-every 3 yrs.
MEDICAL FACILITY FOR OVERSEAS WORKERS AND SEAFARERS	13,500.00	13,500.00	renewal-every 3 yrs.
	w/ 10% disc.	12,150.00	
CASH BOND (MFOWS)	100,000.00		
NEWBORN SCREENING CENTER	8,500.00	8,500.00	renewal-every 3 yrs.
	w/ 10% disc.	7,650.00	
CERTIFICATION as Registered Hospital	50.00		
Re-inspection Fee = 100% of the initial LTO fee			
Other Fees, specify _____			
Penalty for Expired Authorization = 100% surcharge and gap in the validity of the authorization (if less than or equal to 3 months expired)			
For processing as initial. Application for DOH-PTC, DOH-LTO/DOH-COA shall be required (if more than 3 months expired)			
TOTAL (Php)			

** Renewal Fee- with 10% discount from October to November if submitted complete reqmnts

Prepared by:

_____
Licensing Officer/Designate Staff

Received the above payment/s:

Name/Signature: _____

Amount: _____

Cash/PMO/Check. No. Issued _____ Date :_____

OR No. Issued: _____

Date Issued: _____