



**KWAZULU-NATAL PROVINCE**

HEALTH  
REPUBLIC OF SOUTH AFRICA

**LICENSURE APPLICATION**  
**for**  
**CHOICE OF TERMINATION OF PREGNANCY**  
**&**  
**BIRTHING CLINIC**

**COMPLETED APPLICATIONS TOGETHER WITH SUPPORTIVE  
DOCUMENTATION MUST BE FORWARDED TO:**

**THE HEAD OF DEPARTMENT  
DEPARTMENT OF HEALTH –KWAZULU-NATAL  
PRIVATE BAG X9051  
PIETERMARITZBURG  
3200**

**Or DELIVER TO**

**TOWNHILL OFFICE PARK  
BLOCK 2  
35 HYSLOOP ROAD  
PIETERMARITZBURG**

**FOR ATTENTION: PRIVATE LICENSING  
TELEPHONE: 033 9402483/84/88**

**E-mail: [nonhlanhla.ndlovu2@kznhealth.gov.za](mailto:nonhlanhla.ndlovu2@kznhealth.gov.za)**



**KWAZULU-NATAL PROVINCE**

HEALTH  
REPUBLIC OF SOUTH AFRICA

**APPLICATION FOR A CHOICE OF TERMINATION OF PREGNANCY AND/OR BIRTHING CLINIC LICENSE**

Reason for Application			
First time Application	<input type="checkbox"/>	Renewal:	Change Request <input type="checkbox"/>
		Expiration Date:	
		License No:	
Part A: Facility Information			
Facility Name:			
Physical Address:			
Type of Facility	Rented site:	Free standing site	Other
Ownership type (X)	Sole Proprietary	Other (specify and furnish details)	Add details below
Telephone number:		E-mail:	
Number of Procedure rooms:			
Number of beds:			
Other rooms:			
Contact Person and Correspondence mailing Address			
<i>(Name of the license holder and the address where correspondence must be directed)</i>			
First Name/s:		Title:	
Surname:			
Physical address:			
Postal code:		Contact number:	
E-mail address:			
Part B: Operation Disclosure			
<i>(Information in the case of a legal entity to operate the business at the site as indicated in Part A)</i>			
Number of Midwives to run the facility? <i>(attach certificates of registrations)</i>			
Registration details:			
Enter the number of persons (or to be) employed by the Facility according to profession: <i>(attach a list with proof of registration)</i>	1. Registered Nurses		
	2. Nurse Midwives		
	3. Social Workers		
	4. Doctors		
	5. Other <i>(specify &amp; attach information)</i>		

<b>Part C: Services to be Provided under license</b>			
(Indicate below as per Code items 1 and 2 as follows: 1 provided by the licensee, 2. Provided by a contracted services, 3. Both 1 and 2)			
<b>Ancillary Services:</b>	Laboratory <input type="checkbox"/>	Radiology <input type="checkbox"/>	Counselling <input type="checkbox"/>
Sexual & reproductive Health services, e.g. Family planning <input type="checkbox"/>	Pharmacy <input type="checkbox"/>	Other (specify) <input type="checkbox"/>	Specify
<b>Type of Termination Services:</b>	Drug induced only <input type="checkbox"/>	Surgical only <input type="checkbox"/>	Both drug induced & Surgical <input type="checkbox"/>
<b>Part D: Verification</b>			
<p>The application letter to (accompany this form) shall be signed by the following:</p> <p>If an individual, the <i>owner(s)</i></p> <ul style="list-style-type: none"> <li>• If a corporation, <i>two</i> of its <i>officers</i></li> <li>• If non-governmental organisation, the <i>head of the non-governmental organisation</i> having jurisdiction.</li> </ul>			

<b>Part E: Certification of Application</b>	
<p>The undersigned hereby makes application for a license to operate a Termination of Pregnancy clinic in .....(district), and in support of the application, represents and shows that the owner/s and/or operator/s are of reputable and reasonable character, are able to comply with the CHOICE ON TERMINATION OF PREGNANCY AMENDMENT ACT, 2004 (No 27267), the NORMS AND STANDARDS REGULATIONS APPLICABLE TO DIFFERENT CATEGORIES OF HEALTH ESTABLISHMENTS and all applicable statues and rules promulgated, and will operate and maintain the clinic in accordance with those rules.</p> <p>I/we certify that the operational policies of the clinic will not provide for discrimination based on race, colour, creed or national origin.</p> <p>I/we swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I/we will comply with all regulations, laws, and rules governing the licensing of health establishments in KwaZulu Natal.</p>	
Signature of Applicant:	
Print Name and Surname:	
Date of Signature:	
<b>Part D: Additional Information</b>	
<p>Provide additional information to motivate your application, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Feasibility study (<b>compulsory in case of a new site</b>).</li> <li>• Agreement with landlord/s in case of leased site or building</li> <li>• Map indicating the catchment area including existing private and public health establishments</li> <li>• Why is the service needed in that area?</li> <li>• Newspaper notice in at least a local newspaper and a district newspaper</li> <li>• A Full Business Plan, including proposed staffing, supplementary services, and how these will be sourced</li> <li>• Existing agreements with supplementary services; e.g. emergency that need Operating Theatre emergency where the establishment would refer patients.</li> <li>• Any other information deemed important to strengthen the application.</li> </ul>	