Province of the
EASTERN CAPE
SOCIAL DEVELOPMENT

Beacon Hill Office Park - Corner of Hargreaves Road and Hockley Close – Private Bag X0039 – Bhisho – 5605 – REPUBLIC OF SOUTH AFRICA
Tel: +27 (0)43 605 5125 - Fax: +27 (0)43 605 5056 - Email address:vuyelwa.nyati@ecdsd.gov.za - Website: www.ecdsd.gov.za

FORM 4

APPLICATION FOR REGISTRATION OF A TREATMENT CENTRE IN TERMS OF THE PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, 2008 (ACT 70 OF2008)

(Regulation 27)

The following documents must be attached to the application for registration of a private treatment centre:

1. Feasibility study
2. A copy of the constitution of the facility
3. Rezoning certificate/Letter confirming whether rezoning of land is possible (where applicable).
4. Local Authority building plans/schematic sketch of building
5. Detailed treatment programme
6. Daily programme
7. House rules for residents
8. Admission criteria
9. Financial statements (of the previous year, where applicable
10. Means test
11. Medical and psychiatric treatment policy
12. Management structure and staff component
13. Nutritional programme
14. Fees structure
15. Business Plan

PART A

IDENTIFYING PARTICULARS OF FACILITY

1. Name of proposed/existing facility (Name of Facility)

Address

Tel: _____

Fax: _____

E-mail address: _____

Emergency number: _____

Registration number of company/NPO number

2. Area/s of operation

3. Buildings

a) Description of building/buildings

b) Will there be any other buildings and/or activities on the site other than the proposed facility? If so, provide details:

c) Details of other registered facilities, in your area/s.

Name of facility

PART B
SITUATION ANALYSIS

1. What clinical disciplines are/will practiced in the facility?

(Use separate sheet if necessary)

2. What is the extent of the present demand for the service that is/will be provided?

(Use separate sheet if necessary)

3. Have you taken into account existing private and public facilities in your calculation and projections. If yes, how?

(Use separate sheet if necessary)

4. Any other information deemed necessary for this application

(Use separate sheet if necessary)

PART C

PATIENT PROFILE

1. Number of residents for which registration is required:

Adults:

Males _____ Females _____

Children:

Males _____ Females _____

Total _____

2. Will you provide out-patient services? If Yes, supply details

_____

_____

_____

_____

_____

(Use separate sheet if necessary)

15. Treatment period

Time Frame

Short Term (6 weeks)

Long term (6 weeks +)

Re-admission

16. Specify special programmes for long term treatment e.g. education;

Skills training;

_____

_____

_____

_____

_____

_____

_____

_____

3. What arrangements are being made with reference to detoxification?

4. Specify the dependence producing substance applicable to patients treated at the treatment facility

	Alcohol	Dagga	Mandrax	Heroin	Cocaine	Crack	Ecstacy	LSD	Inhalants	Prescription drugs	Other
Adult males											
Adult females											
Male children											
Female children											

PART D

MANAGEMENT STRUCTURE

1. Portfolio Name Address & Contact Details

2. Profession Qualification And Experience

Chairperson

Vice-chairperson

Treasurer

Secretary

Other

PART E

PERSONNEL

Provide a detailed list of your staff established containing the following information: Name, profession, name of board/council, registration number and salary (state whether employees are employed on full time/part-time basis)

The applicant hereby applies for registration as a Treatment Centre/Halfway House in terms of the Prevention and Treatment of and Prevention for Substance Abuse Act, 2008

SIGNED:

CHAIRMAN OF THE APPLICANT: (in the case of an existing treatment centre):

FULL NAMES AND SURNAME:

DATE:

WITNESSES (Management structure members)