



**ACCREDITATION OF HEALTH CARE FACILITY
APPLICATION FORM**

1. Name of health care facility

2. Type of Facility. Tick the appropriate box:

- | | |
|--|--|
| a) <input type="checkbox"/> CHPS Compound | b) <input type="checkbox"/> Maternity Home |
| c) <input type="checkbox"/> Health Centre | d) <input type="checkbox"/> Clinic |
| e) <input type="checkbox"/> Polyclinic | f) <input type="checkbox"/> Primary Hospital |
| g) <input type="checkbox"/> Secondary Hospital | h) <input type="checkbox"/> Tertiary Hospital |
| i) <input type="checkbox"/> Pharmacy | j) <input type="checkbox"/> Chemical Shop |
| k) <input type="checkbox"/> Laboratory | l) <input type="checkbox"/> Ultrasound Scan Centre |
| m) <input type="checkbox"/> Other | |

3. Facility Ownership. Tick the appropriate box:

- | | |
|--|-------------------------------------|
| a) <input type="checkbox"/> Government | b) <input type="checkbox"/> Mission |
| c) <input type="checkbox"/> Quasi-Government | d) <input type="checkbox"/> Private |

4. Category of Application. Tick the appropriate box:

- | | |
|---|--|
| a) <input type="checkbox"/> New Application | b) <input type="checkbox"/> Renewal |
| c) <input type="checkbox"/> Upgrade | d) <input type="checkbox"/> Re-accreditation |
| e) <input type="checkbox"/> Other..... | |

5. Registration of company with Registrar General’s Department:

Business Registration Number	Date Registered	Date Last Renewal

6. Registration of health facility with appropriate regulatory body/bodies:

Regulatory Body	Registration Number	Date Registered	Date Last Renewal

7. Address:

Street address/Location	
Postal address	
Town/City	
District	
Region	
Tel number	
Cell phone number	
Fax number	
Email	
Website	

8. Chief Executive/ Administrator/ Proprietor:

i. Name

i i. Position.....

iii. Contact number (cell phone)

vi. Qualifications

Institution	Qualification	Date

9. Services offered tick the appropriate box:

i. Out-patient

ii. In-patient (24hours)

iii. Maternity

iv. Surgery

v. Ophthalmology

vi. Dental

vii. Pharmacy

viii. Chemical shop

ix. Laboratory

x. Ultrasound scan

xi. Diagnostic X-ray

xii. CT scan

xiii. Pathology (Specialist)

xiv. Orthopaedics (Specialist)

xv. Other

9b. If xv. above is applicable, please specify:

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10. Details of Bank Account

- a. Bankers..... b. Branch.....
- c. Account Name.....
- d. Account Number.....

11. Key Professional Staff

Type of Professional	Number
Medical Practitioners	
Nurses	
Midwives	
Nurse-Midwives	
Pharmacists	
Dispensing Technicians	
Laboratory Technologist	
Laboratory Technicians	
Radiographers/X-ray Technicians	
Medical Assistants	
Doctor Anaesthetist	
Nurse Anaesthetists	
Dentists	
Ophthalmologists	
Other (Please specify)	

12. Attachments

Please attach copies of the following to your completed Application Form:

- a. Certificate of Registration of your facility with the Registrar General’s Department
- b. Certificate of Registration of your facility with appropriate regulatory body/bodies
- c. Proof of retention of your facility with regulatory body/bodies
- d. Certificate of qualification of heads of departments/units
- e. Proof of retention of heads of departments/units with regulatory body/bodies where applicable
- f. PIN of nurses/midwives where applicable
- g. List of names of all professional staff, indicating whether they are full-time or part-time. Please use the format shown below.
- h. Receipt of payment of applicable Accreditation Application fee.

13. Format for listing names of professional staff (See g. under 12 above)

Please use the following format to list your professional staff.

Name of Professional	Rank / Position	Please tick whether permanent or temporary		If temporary /locum, permanent place of work
		Permanent	Temporary/locum	

14. Declaration

I,, the Chief Executive/
 Administrator/Proprietor of
 hereby declare that the information given above is correct and that I will be responsible for any falsehood provided.

Signature Date

OFFICIAL USE ONLY

Received by.....

Receipt No.....

Signature of Officer..... Date.....