**QAI CAHSC 102**

**Quality and Accreditation Institute**

**Centre for Accreditation of Health & Social Care**



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**ASSISTED REPRODUCTIVE TECHNOLOGY (ART) CENTRES**

**Issue No.: 02 Issue Date: August 2019**

**CHANGE HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Doc No.** | **Current Issue No.** | **Revised Issue No.** | **Date of Issue** | **Reasons** |
| 1 | CAHSC 102 | 01 | 02 | August 2019(20.08.2019) | Removed the fee structure Terms & condition of maintaining accreditation line edited i.e. certification is added  |
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**Information & Instructions for Completing an Application Form**

Quality & Accreditation Institute (QAI)’s Centre for Accreditation of Health & Social Care (**CAHSC**) offers accreditation services to Assisted Reproductive Technology (ART) Centres.

Application shall be made in the prescribed form QAI CAHSC 102 only. Application form can be downloaded from website as a word file. Applicant organisation is requested to submit the following:

* Three copies of completed application forms
* Self-assessment tool kit along with referenced documents **(soft copy)**
* Prescribed application fees (details given in this section)
* Signed copy of QAI CAHSC 003 ‘Terms and Conditions for Maintaining QAI Accreditation and Certification’

Incomplete application and insufficient number of copies submitted may lead to delay in processing of your application.

The applicant organisation shall provide copy of appropriate document(s) in support of the information being provided in this application form.

Organisation is advised to familiarize itself with QAI CAHSC 002 ‘General Information Brochure, QAI CAHSC 101 Information Brochure for Accreditation of ART Centres’ and QAI CAHSC 003 ‘Terms and Conditions for Obtaining and Maintaining Accreditation and Certification’ before filling up this form.

The applicant organisation shall intimate QAI CAHSC about any change in the information provided in this application such as scope applied for accreditation, personnel and location etc. within 15 days from the date of changes.

Completed application may please be sent to:

Quality and Accreditation Institute Pvt. Ltd.
416, Krishna Apra Plaza, Sector 18
Noida-201301, U.P., India
Tel.: +91-120 4113234

**DEMOGRAPHIC AND GENERAL DETAILS:**

1. **Applying for (please tick the relevant)**
	1. **First accreditation\* □**

**\*** *(ART Centres are advised to implement the standards for at least 2 months before applying)*

* 1. **Renewal of accreditation □**

**Date of 1st accreditation …..……………**

1. **Name of the ART Centre:** (the same shall appear on the accreditation certificate)

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1. **Contact Details of Centre:**

**Address**

**City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pin code**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email ID:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact No**.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Website*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

1. **Ownership:**

|  |  |
| --- | --- |
| **□** Private | **□** Armed Forces |
| **□** PSU | **□** Trust |
| **□** Government | **□** Charitable |
| **□** Others (Specifiy.........................................................................................) |

1. **Name of the Parent Organisation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (if the centre is part of a bigger organisation)

Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Legal identity of the ART centre and date of establishment** (Please give registration number and name of authority who granted the registration. Copy of the certificate shall be enclosed) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Contact person(s):**
* **Head of the ART Centre**

Mr. /Ms. /Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Person Coordinating with QAI:**

Mr./Ms./Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **ART Centre Information:**
2. **Total no. of day care beds (If any):**
3. **Number of OTs:**

**CLINICAL SERVICES AND RELATED DETAILS**

1. **Patient Data:**
2. **Patient Data (Past 2 years)**

|  |  |
| --- | --- |
| **Year** | **Number of Patients** |
|  |  |
|  |  |

1. **Number of Embryos transferred (Past 2 years)**

|  |  |
| --- | --- |
| **Year** | **Number of Embryos Transferred** |
|  |  |
|  |  |

1. **List 5 most frequent clinical diagnosis for patients**
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **List 5 most frequent procedures done for patients**
8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. **Scope of Accreditation – Treatment/Procedures in the ART Centre:**

|  |  |
| --- | --- |
| Treatment/ Procedure | **AVAILABILITY OF TREATMENT/ PROCEDURE****YES/NO** |
| **Counselling** |  |
| **Donor Program** |  |
| **Embryology laboratory** |  |
| **Embryoscopy** |  |
| **Gamete Intra Fallopian Transfer (GIFT)** |  |
| **In Vitro Fertilization (IVF)** |  |
| **Intra Cytoplasmic Sperm Injection (ICSI)** |  |
| **Laparoscopy & Hysteroscopy** |  |
| **Laser Assisted Hatching** |  |
| **Micro Epididymal Sperm Aspiration (MESA)** |  |
| **Oocyte retrieval** |  |
| **Oocyte/Embryo/blastocyst cryopreservation** |  |
| **Operation theatre** |  |
| **Other procedures involving manipulation of gamete, embryo, and gonadal tissue** |  |
| **Percutaneous Epididymal Sperm Aspiration (PESA)** |  |
| **Preimplantation Genetic Diagnosis (PGD)** |  |
| **Reproductive Genetics** |  |
| **Semen Analysis (recognized standards e.g. WHO)** |  |
| **Sperm cryopreservation** |  |
| **Sperm preparation (Fresh sample/frozen sample/MESA/PESA/TESE/ TESA/Open Biopsy)** |  |
| **Surrogacy** |  |
| **Testicular Sperm Aspiration (TESA)** |  |
| **Testicular Sperm Extraction (TESE)** |  |
| **Ultrasonography** |  |
| **Any other (please mention)** |  |

1. **Details of Non Clinical and Administrative Departments (mention Yes/ No):**

|  |  |  |
| --- | --- | --- |
| **SUPPORT SERVICE** | **IN HOUSE** | **OUT SOURCED** |
| **Bio-medical Engineering** |  |  |
| **Catering and Kitchen services** |  |  |
| **CSSD** |  |  |
| **General Administration** |  |  |
| **Housekeeping** |  |  |
| **Human Resources** |  |  |
| **Information Technology** |  |  |
| **Laundry** |  |  |
| **Maintenance/Facility Management** |  |  |
| **Management of Bio-medical Waste** |  |  |
| **Pharmacy** |  |  |
| **Security**  |  |  |
| **Community Service** |  |  |
| **Supply Chain Management/** **Material Management** |  |  |
| **Other, please specify** |  |  |

1. **Details of Human Resource**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sl. No.** | **Name** | **Designation** | **Academic and professional qualifications** | **Experience related to present work (in years)** |
|  |  |  |  |  |
|  |  |  |  |  |

1. **Statutory Compliances**

**Furnish details of applicable Statutory/ Regulatory requirements the facility is governed by (*Please attach copies of applicable documents)*:**

|  |  |  |  |
| --- | --- | --- | --- |
| **License/Certificate** | **Number and Date of issue** | **Valid Up to** | **Remarks**  |
| ***General:*** |
| Bio-medical Waste Management and Handling Authorization |  |  |  |
| Registration Under Clinical Establishment Act (or equivalent) |  |  |  |
| Registration Under PCPNDT Act |  |  |  |
| ***Facility management:*** |
| Fire (NOC) |  |  |  |
| License to Store Compressed Gas |  |  |  |
| Sanction/ License for Lifts |  |  |  |
| *Pharmacy (if over multiple locations license for each of them separately)* |
| Drugs-Bulk license |  |  |  |
| Drugs-Retail license |  |  |  |
| Narcotic license |  |  |  |
| ***Miscellaneous:*** |
| Canteen/ F & B license |  |  |  |
| License for Possession and Use of Methylated Spirit, Denatured spirit and Methyl alcohol |  |  |  |
| License for Possession of Rectified Spirit and ENA |  |  |  |
| ***Any other:*** |

1. **Litigation, if any:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Date of last Self-assessment:** ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Date of implementation of QAI standards:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(ART Centre is advised to implement the standards for at least 2 months before applying)*

1. **Application Fees**

  Application fees (Rs.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DD/At par cheque number/ bank transfer reference number\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Date Application Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Undertaking**
* We are familiar with the terms and conditions of maintaining accreditation and certification (QAI CAHSC 003), which is signed and enclosed with the application. We also undertake to abide by them.
* We agree to comply fully with the requirements of the standards for the accreditation of facility.
* We agree to comply with accreditation procedures and pay all costs for any assessment carried out irrespective of the result.
* We agree to co-operate with the assessment team appointed by QAI CAHSC for examination of all relevant documents by them and their visits to those parts of the facility that are part of the scope of accreditation.
* We undertake to satisfy all national, regional and local regulatory requirements for operating the facility.
* All information provided in this application is true to the best of our knowledge and ability.

Authorised Signatory (Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Centre for Accreditation of Health & Social Care

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Noida-201301, U.P., India

**Tel**.: +91-120 4113234

**Website**: www.org.in

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