**QAI CAHSC 502**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**WHO PATIENT SAFETY FRIENDLY HOSPITAL STANDARDS (PSFHS)**

**CERTIFICATION PROGRAM**

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

**CHANGE HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Doc. No.** | **Current Issue No.** | **Revised Issue No.** | **Date of Issue** | **Reasons** |
| 1 | QAI CAHSC 502 | 1 | 2 | August 2019  (20.08.2019) | Removed the fee structure  Terms and conditions of maintaining accreditation line edited i.e. certification is added |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
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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 Certification to hospitals using WHO Patient Safety Friendly Hospital Standards (PSFHS).

Application shall be made in the prescribed form QAI CAHSC 502 only. Application form can be downloaded from website as a word file. Applicant organisation is requested to submit the following:

* Completed application form **(Soft Copy)**
* 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 & 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 501 Information Brochure for Certification of Patient Safety Friendly Hospital Standards (PSFHS) and QAI CAHSC 003 ‘Terms and Conditions for Obtaining and Maintaining Accreditation & 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 certification, 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 Certification □**
   2. **Renewal of Certification □**

**Date of 1st Certification**

1. **Has hospital received accreditation from any Accreditation Body, if yes, please write the name:**

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

1. **Name of the Hospital:** (the same shall appear on the certificate)

1. **Contact Details of the Hospital:**

**Address:**

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

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

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

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

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

1. **Ownership:**

* Private
* PSU
* Government
* Armed Forces
* Trust
* Others (Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

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

(If the hospital is part of a bigger organisation)

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact No. & E-mail** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Legal identity of the Hospital and the date of establishment** (Please give registration number and name of authority who granted the registration. Copy of the certificate shall be enclosed)

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

1. **Contact person(s) :**

* **Head of the Hospital:**

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

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

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

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

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

* **Person Coordinating with QAI:**

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

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

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

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

**E-mail**:

1. **Some Statistics:**
2. Number of inpatient beds (currently in operation):
3. Average daily inpatient census (last 2 years): \_\_\_\_\_\_
4. Annual ambulatory/outpatient visits (last 2 years):
5. Annual emergency room visits (last 2 years):
6. Number of OTs:
7. Number of ICU beds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. **List the types of medical services provided by the hospital: (e.g. Medicines, Orthopaedics)**

**­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **List top five medical discharge diagnoses:**

**a)**

**b)**

**c)**

**d)**

**e)** \_\_\_\_\_\_

1. **List top five surgical procedures:**

**a)**

**b)**

**c)**

**d)**

**e)** \_\_\_\_\_\_\_

1. **List non-medical services that support the hospital:**

**a)**

**b)**

**c)**

**d)**

**e)**

1. **List any contracted (outsourced) services:**

**a)**

**b)**

**c)**

**d)**

**e)** \_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you operate ambulances? If yes, how many?**
2. **Site description: list all the buildings affiliated with the hospital:**

1. **Application Fees :**

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

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

1. **Undertaking:**

* We are familiar with the terms and conditions of maintaining accreditation & 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 certification of hospital.
* We agree to comply with certification 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 hospital that are part of the scope of certification.
* We undertake to satisfy all national, regional and local regulatory requirements for operating the hospital.
* All information provided in this application is true to the best of our knowledge and ability.

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

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

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

**Date: ­­­­­­­­­­­­­­­­­­­­**­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quality and Accreditation Institute

Centre for Accreditation of Health & Social Care

416, Krishna Apra Plaza, Sector 18

Noida-201301, U.P., India

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

**Website**: www.org.in

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