**QAI CAHSC 602**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**GREEN HEALTH CARE FACILITY ACCREDITATION PROGRAM**

**Issue No.: 02 Issue Date: August 20**

**CHANGE HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Doc. No.** | **Current Issue No.** | **Revised Issue No.** | **Date of Issue** | **Reasons** |
| 1 | QAI CAHSC 602 | 1 | 2 | August 2019(20.08.2019) | Removed the fee structureTerms and conditions of maintaining accreditation line edited i.e. certification is added |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |

**Information & Instructions for Completing an Application Form**

Quality & Accreditation Institute (QAI)’s Centre for Accreditation of Health & Social Care (**CAHSC**) offers Accreditation to Health Care Facility using Green Health Care Facility.

Application shall be made in the prescribed form QAI CAHSC 602 only. Application form can be downloaded from website as a word file. Applicant organisation is requested to submit the following:

* Soft Copy of completed application form
* Soft copy of Self-assessment tool kit along with referenced documents
* Prescribed application fees (details given in this section)
* Soft copy of signed 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 601 Information Brochure for Accreditation of Health Care Facility 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 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 □**
	2. **Renewal of Accreditation □**

**Date of 1st Accreditation**

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

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

1. **Name of the Health Care Facility:** (the same shall appear on the certificate)

1. **Contact Details of the Health Care Facility:**

**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 Health Care Facility is part of a bigger organisation)

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

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

1. **Legal identity of the Health Care Facility 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 Health Care Facility:**

**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. **Site description: list all the buildings affiliated with the Health Care Facility:**

1. **Source(s) of Energy used in the facility along with their capacity:**

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

1. **Statutory/ Regulatory/ Legal Compliance**

Furnish details of following mandatory Statutory/ Regulatory requirements the healthcare facility is governed by:

|  |  |  |  |
| --- | --- | --- | --- |
| **Details** | **Licence Number**  | **Valid Upto** | **Remarks** (related to renewal/ in process) |
| Registration Under Clinical Establishment Act (or similar) |  |  |  |
| Registration With Local Authorities |  |  |  |
| Bio-medical Waste Management and Handling Authorization |  |  |  |
| License under Environmental Act (Air, Water and Noise) |  |  |  |

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 accreditation of green Health Care 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 Health Care Facility that are part of the scope of accreditation.
* We undertake to satisfy all national, regional and local regulatory requirements for operating the Health Care Facility.
* 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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