**QAI CAHSC 1002**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**ACCREDITATION OF TELEHEALTH FACILITY**

**Issue No.: 03 Issue Date: February 2022**

**CHANGE HISTORY**

|  |  |  |  |  |  |
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| **Sl. No.** | **Doc. No.** | **Current Issue No.** | **New Issue No.** | **Date of Issue** | **Reasons** |
| 1. | CAHSC 1002 | 01 | 02 | March 2021 | * City added in point 2 of clause 2. * Goods and Services Tax (GST) and MSME Registration clause added (5 and 6) |
| 2 | CAHSC 1002 | 2 | 3 | February 2021  (19 February 21) | Sl. No. 10 modified |
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**Information & Instructions for Completing an Application Form**

1. Quality & Accreditation Institute (QAI)’s Centre for Accreditation of Health & Social Care (**CAHSC**) offers accreditation services to Telehealth Facility.
2. Application shall be made in the prescribed form QAI CAHSC 1002 only. Application form can be downloaded from website as a word file. Applicant facility is requested to submit the following:

* Soft copy of completed application forms (available on website)
* Soft copy of Self-assessment tool kit along with referenced documents
* Prescribed application fees
* Soft copy of signed QAI-CAHSC 003 ‘Terms and Conditions for Obtaining and Maintaining Accreditation/ Certification’

1. Incomplete application submitted may lead to delay in processing of your application.
2. The applicant facility shall provide soft copy of appropriate document(s) in support of the information being provided in this application form.
3. Facility is advised to familiarise itself with QAI CAHSC 002 ‘General Information Brochure, QAI CAHSC 1001 Information Brochure for Accreditation Programme for Telehealth facility’ and QAI CAHSC 003 ‘Terms and Conditions for Maintaining Accreditation/ Certification’ before filling up this form.
4. The applicant facility 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.

**DEMOGRAPHIC AND GENERAL DETAILS:**

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

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

**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 facility is part of a bigger organisation)

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

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

1. **Goods and Services Tax (GST) Number** (Please attach a copy of GST Registration Certificate):

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1. **Micro, Small and Medium Enterprises (MSME) Registration Number** (Please attach a copy of Registration Certificate):

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1. **Legal identity of the facility and 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 Facility**

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

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

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* **Person Coordinating with QAI:**

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

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

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **Tools used for communication to provide teleconsultation:(Tick the tools used):**

|  |  |
| --- | --- |
| **Tools** | **√ the applicable** |
| Audio-video systems like telephone (mobile and landline) |  |
| Internet based digital platforms |  |
| Mobile/ Internet based chat platforms |  |

1. **Telehealth Data**

|  |  |  |
| --- | --- | --- |
| **Average number of consultations per Day** | **Select the applicable category** | **Please mention number of consultations** |
| Less than 100 |  |  |
| 101-1000 |  |  |
| More than 1000 |  |  |

1. **Type of Services of Telehealth Facility**

|  |  |  |
| --- | --- | --- |
| **Sl. No.** | **Service** | **Please select as applicable** |
| 1 | Patient to Provider |  |
| 2 | Patient to Provider through Caregiver |  |
| 3 | Health worker to Provider |  |
| 4 | Provider to Provider |  |

1. **Scope of Services:** (Please describe services being offered e.g. teleconsultation in various

clinical fields, teleradiology, telepathology, tele ICU)

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1. **Number of RMP/RHP/ASU RMP/ YN RMP giving Teleconsultation in the Facility:**

**(You may attach a sheet)**

**Note: Provide Registration Number of RMP/RHP/ASU RMP/ YN RMP accorded by State Medical Council/MCI or Central Council of Homeopathy or Central Council of Indian Medicine** **or Central Council for Research in Yoga & Naturopathy** **and Name of the Registration Council of providing teleconsultation in following format:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sl. No.** | **Name of RMP/RHP/ASU RMP/**  **YN RMP** | **Registration Number** | **Name of Registration Council** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **Staff Information:**

|  |  |  |
| --- | --- | --- |
| **Category of Staff** | **Numbers** | **Remarks if any** |
|  |  |  |
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1. **Statutory/ Regulatory/ Legal Compliance**

Furnish details of all applicable including following mandatory Statutory/ Regulatory requirements the facility is governed by: (Please submit scanned copies of License/ Certificate)

|  |  |  |  |
| --- | --- | --- | --- |
| **Details** | **Licence Number** | **Valid Upto** | **Remarks**  (related to renewal/ in process) |
| **Registration Under Clinical Establishment Act (or similar)** |  |  |  |
| **Registration with Local Authorities** |  |  |  |
| **Fire NOC or equivalent, as applicable** |  |  |  |
| **Others, please specify** |  |  |  |

1. **Litigation, if any:**
2. **Date of implementation of QAI Telehealth Accreditation Standards:**

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 Telehealth accreditation programme.
* We agree to comply with Telehealth accreditation procedures and pay all costs 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

Quality and Accreditation Institute

Centre for Accreditation of Health & Social Care

**Website**: www.qai.org.in

Twitter: @QAI2017