**QAI CAHSC 802**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**ACCREDITATION OF CLINICS**

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

**CHANGE HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Doc. No.** | **Current Issue No.** | **New Issue No.** | **Date of Issue** | **Reasons** |
| 1. | CAHSC 802 | 01 | 02 | March 2021  (20 March 2021) | * City added in point 2 of clause 3. * Goods and Services Tax (GST) and MSME Registration clause added (6 and 7) * Primary care clinic added in point 2 of clause 19. |
| 2. | CAHSC 802 | 02 | 03 | September 2022  (28 September 2022) | * Primary Care Clinic changed to Clinics |
|  |  |  |  |  |  |
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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 Clinics.
2. Application shall be made in the prescribed form QAI CAHSC 802 only. Application form can be downloaded from website as a word file. Applicant 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 shall provide soft copy of appropriate document(s) in support of the information being provided in this application form.
3. Clinic/Facility is advised to familiarise itself with QAI CAHSC 002 ‘General Information Brochure, QAI CAHSC 801 Information Brochure for ‘Clinics’ and QAI CAHSC 003 ‘Terms and Conditions for Maintaining Accreditation/Certification’ before filling up this form.
4. The applicant 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. **Applying for (please tick the relevant)**
   1. **First accreditation\* □**

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

* 1. **Renewal of accreditation □**

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

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

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

**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 Clinic is part of a bigger organisation)

Telephone No.

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

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

­­­­­­

1. **Legal identity of the Clinic and date of establishment in relation to ownership mentioned at sl. no. 4 above** (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 Clinic**

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

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

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

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

* **Person Coordinating with QAI:**

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

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

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

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

1. **Average daily OPD Attendance:**
   1. **New Patients**
   2. **Old Patients**
2. **Scope of Accreditation (Please refer to the Information Brochure):**

|  |
| --- |
| **Services Available at the Clinic** |
| Clinical disciplines/ specialities: |
| Diagnostic services (Laboratory): |
| Diagnostic services (Imaging): |
| Allied/ Support Services: |

1. **Staff Information:**

|  |  |  |
| --- | --- | --- |
| **Category of Staff** | **Numbers** | **Remarks if any** |
| Doctors |  |  |
| Nurses |  |  |
| Housekeeping staff |  |  |
| Others |  |  |

**Please provide details of all staff in the following table (kindly add rows as required):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sl. No.** | **Name** | **Qualification** | **Experience (months/years)** | **Registration/Licence Number** |
|  |  |  |  |  |
|  |  |  |  |  |

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Details** | **Licence Number** | **Valid Up-to** | **Remarks**  (e.g., renewal in process) |
| **Registration Under Clinical Establishment Act (or similar)** |  |  |  |
| **Bio-medical Waste Management and Handling Authorization** |  |  |  |
| **Fire NOC or equivalent, as applicable** |  |  |  |
| **PCPNDT Registration** |  |  |  |
| **AERB Certificate for Radiation Devices (X-Ray, Mammography)** |  |  |  |

1. **Litigation, if any:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Date of last self-assessment:** ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Date of implementation of QAI standards:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Clinic 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/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 Clinics accreditation standards.
* 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

**Quality and Accreditation Institute**

Centre for Accreditation of Health & Social Care

Website: www.qai.org.in

Twitter: @QAI2017