**QAI CAHSC 702I**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**AMBULATORY CARE FACILITY - IMAGING**

**Issue No.: 02 Issue Date: March 2021**

**CHANGE HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Doc No.** | **Current Issue No.** | **Revised Issue No.** | **Date of Issue** | **Reasons** |
| 1. | CAHSC 702I | 01 | 02 | March 2021(20 March 2021) | * Changed word organisation to facility.
* City added in point 2 of clause 3.
* Goods and Services Tax (GST) and MSME Registration clause added (6 and 7)
* Ambulatory added in point 2 of clause 25.
* Added date under authorised signatory (signature).
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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 Ambulatory Care Facility.
2. Application shall be made in the prescribed form QAI CAHSC 702I 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 form (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 701I Information Brochure for Ambulatory Care Facility-Imaging’ and QAI CAHSC 003 ‘Terms and Conditions for Obtaining and 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 accreditation, 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\* □**

**\*** *(Ambulatory Care Facility Imaging is advised to implement the standards for at least 2*

*month before applying)*

* 1. **Renewal of accreditation □**

**Date of 1st accreditation……………….…**

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

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

**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 ACFI 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):

­­­­­­

1. **Legal identity of the Ambulatory Care Facility Imaging 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 Ambulatory Care Facility Imaging:**

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

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

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

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

* **Person Coordinating with QAI:**

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

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

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

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

1. **Details regarding Ultrasound Equipment registration with PC-PNDT:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Equipment** | **Registration number and date** | **Valid Upto** | **Remarks (if any)** |
|  |  |  |  |
|  |  |  |  |

1. **Details regarding AERB approval of equipment, facility design and installation, Operation certificate and Personnel:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Equipment**  | **License/ Certificate**  | **Number and Date** | **Valid upto** | **Remarks (if any)** |
|  | **NOC/Type-approval****certificate of Equipment** |  |  |  |
| **Site Layout approval** |  |  |  |
| **Installation/Operation****Certificate** |  |  |  |
| **Personnel (RSO)** |  |  |  |

1. **For Imaging Facility: (Based on number of modalities)**

|  |  |
| --- | --- |
| **Number of Modality (s)** | **Please Tick** |
| **Small Practice, 1 modality** |  |
| **Medium Practice, 2 modalities** |  |
| **Large Practice, 3 or above modalities** |  |

**CLINICAL SERVICES AND RELATED DETAILS**

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

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

1. **List 5 most frequent clinical diagnosis for patients**
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **Scope of Accreditation – Treatment/Procedures in the Ambulatory Care Facility Imaging**

|  |  |  |
| --- | --- | --- |
| MODALITY(S) | **MODALITY(S)** | **AVAILABILITY OF TREATMENT/ PROCEDURE****YES/NO** |
| Audiometry |  |  |
| Bone Mineral Densitometry | * Dual Energy X Ray Absorptiometry (DEXA)
* Quantitative Computed Tomography (QCT)
* Quantitative Ultrasound (QUS)
 |  |
| Computed Tomography (CT) Scan | * CT Imaging
* Cone Beam Computed Tomography
* CT guided procedures
 |  |
| Dental X-ray | * Dental X-ray
 |  |
| Echocardiogram (ECHO) |  |  |
| Electrocardiogram (ECG) |  |  |
| Electroencephalography (EEG) |  |  |
| Electromyography (EMG)/ Evoke Potential (EP) |  |  |
| Fluoroscopy based Radiographic Procedures | * Fluoroscopy based Investigative Procedures
 |  |
| Holter Monitoring |  |  |
| Interventional Procedures | * Fluoroscopy Guided Vascular Procedures
* Fluoroscopy Guided Non-Vascular Procedures
* Angiography/Cardiovascular Labs setups for vascular imaging

and interventional procedures |  |
| Magnetic Resonance Imaging (MRI) | * MR imaging
* MR guided procedures
* MR guided HIFU
 |  |
| Mammography | * Mammography
* Interventional Procedures
 |  |
| Nerve Conduction Velocity (NCV) |  |  |
| Nuclear Medicine | * Plainer Gamma Camera
* SPECT/SPECT CT
* Positron Emission Tomography –(PET)/PET-CT
* Radionuclide therapy
 |  |
| OPG | * OPG
 |  |
| Radiography | * General Radiography
* Dental Radiography
 |  |
| Spirometry |  |  |
| Tread Mill Testing (TMT) |  |  |
| Ultrasound | * General Ultrasound
* Colour Doppler flow imaging
* Interventional procedures
* USG guided HIFU
 |  |
| Uroflowmetry (UF) |  |  |
| Others, please specify | * Radio frequency ablation (RFA) and Laser / Cryoablation /

Thermoablation* Tele radiology
* Any other imaging service
 |  |

1. **Equipment: Details of all equipments in the Medical Imaging Services**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **S.No.**  | **Name of Equipment**  | **Make /Model** | **Date of Installation**  | **AMC/ CMC status**  | **Average patient load**  |
|  |  |  |  |  |  |
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 **Note: Each equipment should be listed separately**

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)** |
|  |  |  |  |  |
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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 Authorisation |  |  |  |
| 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:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Ambulatory Care Facility Imaging 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 Ambulatory 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