**QAI CAHSC 1102**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**Application Form**

**for**

**Accreditation of Hospitals**

**Issue No.: 01 Issue Date: August 2022**

**CHANGE HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Doc. No.** | **Current Issue No.** | **New Issue No.** | **Date of Issue** | **Reasons** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**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 Hospitals.
2. Application shall be made in the prescribed form QAI CAHSC 1101 only. Application form can be downloaded from website as a word file. Applicant Hospital 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 Maintaining QAI Accreditation/ Certification’

1. Incomplete application submitted may lead to delay in processing of your application.
2. The applicant hospital shall provide soft-copy of appropriate document(s) in support of the information being provided in this application form.
3. Hospital is advised to familiarize itself with QAI CAHSC 002 ‘General Information Brochure’, QAI CAHSC 1101 ‘Information Brochure for Accreditation of Hospitals’ and QAI CAHSC 003 ‘Terms and Conditions for Maintaining Accreditation/ Certification’ before filling up this form.
4. The applicant Hospital 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 □**
   2. **Renewal of accreditation □**

**Date of 1st accreditation ….……………**

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

---------------------------------------------------------------------------------------------------------------

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

**Address**

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

**Pincode:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**Website*:***

1. **Ownership:**

|  |  |
| --- | --- |
| **□** Private | **□** Armed Forces |
| **□** PSU | **□** Trust |
| **□** Government | **□** Charitable |
| **□** Others (Specifiy.........................................................................................) | |

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

(if the hospital 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, if applicable):

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

­­­­­­

1. **Legal identity of the Hospital and date of establishment** (Please give registration number and name of authority who granted the registration in relation to ownership as per sl. no. 4 above. Copy of the certificate shall be enclosed)

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

* **Head of the Hospital**

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

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

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

* **Person Coordinating with QAI:**

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

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

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

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

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

1. **Information of Hospital and Services:**
2. **Total number of sanctioned beds:**
3. **Total number of beds currently in operation:**

(Exclude emergency, day-care, recovery room beds, labour room beds from this number)

|  |  |
| --- | --- |
| **Bed Type** | **Number of Beds** |
| In-patient beds (non-ICU) |  |
| In-patient beds (ICU) |  |
| **Total** |  |

|  |  |
| --- | --- |
| **Others:** |  |
| * Emergency beds |  |
| * Day-care beds |  |
| * Recovery room beds |  |
| * Labour room beds |  |
| * Dialysis |  |
| * Any other (Specify) |  |

1. **Number of OTs:**

**General: Super-speciality:**

**d. Layout of the Hospital (**Number of buildings) ­­­­­­

1. **Does the hospital provide treatment through alternative medicines (other than allopathic medicine), e.g. AYUSH:**

**If yes, please specify:**

**CLINICAL SERVICES AND RELATED DETAILS**

1. **OPD and IPD data:**
2. **OPD DATA (Past 2 years)**

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

1. **IPD DATA (Past 2 years)**

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

1. **Average Occupancy Rate:**
2. **List five most frequent clinical diagnosis for in-patients:**
   1. ……………………………
   2. ……………………………
   3. ……………………………
   4. ……………………………
   5. ……………………………
3. **List five most frequent surgical procedures done for in-patients**
4. ……………………………
5. ……………………………
6. ……………………………
7. ……………………………
8. ……………………………
9. **Scope of Accreditation–Clinical Specialities in the Hospital:**

| **Speciality** | **Service Provided**  **(YES or NO)** | **Number of Consultants** |
| --- | --- | --- |
| Anaesthesiology |  |  |
| Cardiac Anaesthesia |  |  |
| Cardiology |  |  |
| Cardiothoracic Surgery |  |  |
| Clinical Haematology |  |  |
| Critical Care |  |  |
| Dermatology and Venereology |  |  |
| Emergency Medicine |  |  |
| Endocrinology |  |  |
| Family Medicine |  |  |
| General Medicine |  |  |
| Geriatrics |  |  |
| General Surgery |  |  |
| Hepatology |  |  |
| Hepato-Pancreato-Biliary Surgery |  |  |
| Immunology |  |  |
| Medical Gastroenterology |  |  |
| Neonatology |  |  |
| Nephrology |  |  |
| Neurology |  |  |
| Neuro-Radiology |  |  |
| Neurosurgery |  |  |
| Nuclear Medicine |  |  |
| Obstetrics and Gynaecology |  |  |
| Oncology |  |  |
| * Medical Oncology |  |  |
| * Radiation Oncology |  |  |
| * Surgical Oncology |  |  |
| Ophthalmology |  |  |
| Orthopaedic Surgery |  |  |
| Otorhinolaryngology |  |  |
| Paediatrics |  |  |
| Paediatric Gastroenterology |  |  |
| Paediatric Cardiology |  |  |
| Paediatric Surgery |  |  |
| Psychiatry |  |  |
| Plastic and Reconstructive Surgery |  |  |
| Respiratory Medicine |  |  |
| Rheumatology |  |  |
| Sports Medicine |  |  |
| Surgical Gastroenterology |  |  |
| Urology |  |  |
| Vascular Surgery |  |  |
| Transplantation Service |  |  |
| Day Care Services |  |  |
| Any other |  |  |

1. **Scope of Accreditation - Diagnostic Services in the Hospital (mention Yes/ No):**

**(ONLY IN-HOUSE SERVICES WILL BE INCLUDED IN THE ACCREDITATION)**

| **Diagnostic Services** | **In House** | **Out sourced** |
| --- | --- | --- |
| ***Diagnostic Imaging:*** |  |  |
| Bone Densitometry |  |  |
| CT Scanning |  |  |
| DSA Lab |  |  |
| Gamma Camera |  |  |
| Mammography |  |  |
| MRI |  |  |
| PET |  |  |
| Ultrasound |  |  |
| X-Ray |  |  |
| ***Laboratory Services:*** |  |  |
| Clinical Bio-chemistry |  |  |
| Clinical Microbiology and Serology |  |  |
| Clinical Pathology |  |  |
| Cytopathology |  |  |
| Genetics |  |  |
| Haematology |  |  |
| Histopathology |  |  |
| Molecular Biology |  |  |
| Toxicology |  |  |
| ***Other Diagnostic Services:*** |  |  |
| 2D Echo |  |  |
| Audiometry |  |  |
| EEG |  |  |
| EMG/EP |  |  |
| Holter Monitoring |  |  |
| Spirometry |  |  |
| Tread Mill Testing |  |  |
| Urodynamic Studies |  |  |
| *Any Other Diagnostic Service (s):* |  |  |
|  |  |  |

1. **Scope of Accreditation - Clinical Support departments/services in the Hospital (mention Yes/ No):**

**(ONLY IN-HOUSE SERVICES WILL BE INCLUDED IN THE ACCREDITATION)**

|  |  |  |
| --- | --- | --- |
| **Services** | **In House** | **Out sourced** |
| Ambulance |  |  |
| Blood Bank |  |  |
| Dietetics |  |  |
| Pharmacy |  |  |
| Psychology |  |  |
| Rehabilitation |  |  |
| * Occupational Therapy |  |  |
| * Physiotherapy |  |  |
| * Speech and Language Therapy |  |  |

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 |  |  |
| Mortuary Services |  |  |
| Security |  |  |
| Community Service |  |  |
| Supply Chain Management/ Material Management |  |  |
| Other, please specify |  |  |
|  |  |  |

1. **Staff Information:**

| **Category of Staff** | **Numbers** | **Remarks if any** |
| --- | --- | --- |
| Managerial |  |  |
| Doctors |  |  |
| * Resident (non-PG)/ Medical Officer |  |  |
| * Consultants |  |  |
| a) Full Time |  |  |
| b) Part Time |  |  |
| Allied Medical Speciality Staff |  |  |
| Nurses |  |  |
| Technicians |  |  |
| Housekeeping staff |  |  |
| Others |  |  |

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

Furnish details of the following mandatory Statutory/ Regulatory requirements as applicable to the hospital (Please submit scanned copies of License/Certificate)

| **Details** | **Licence Number** | **Valid Upto** | **Remarks**  (e.g., renewal under process) |
| --- | --- | --- | --- |
| Registration Under Clinical Establishment Act (or similar) |  |  |  |
| Registration with Local Authority, if other than above |  |  |  |
| Bio-medical Waste Management and Handling Authorization |  |  |  |
| License for MTP |  |  |  |
| License for PNDT |  |  |  |
| License under NDPS |  |  |  |
| Fire NOC or equivalent, as applicable |  |  |  |
| Any other, as applicable |  |  |  |
| Registration for all Modalities from AERB: | | | |
| License to operate CT |  |  |  |
| License to operate X-Ray |  |  |  |
| License to operate C-Arm |  |  |  |
| License to operate X-Ray based Bone Densitometer |  |  |  |
| License for any Radiation emitting device |  |  |  |
| License to Operate Nuclear Medicine Lab |  |  |  |
| License to operate Radiation Therapy Department |  |  |  |

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

*(Hospital must implement the standards for at least 2 months before applying)*

1. **Application Fees** (Rs.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank transfer reference number\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Date of 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 accreditation requirements including accreditation standards hospital.
* 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 hospital that are part of the scope of accreditation.
* We undertake to satisfy applicable 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

Website: www.qai.org.in

Twitter: @QAI2017