**QAI CAHSC 402**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**CERTIFICATION OF HOSPITALS**

**Issue No.: 05 Issue Date: January 2023**

**CHANGE HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Doc. No.** | **Current Issue No.** | **New Issue No.** | **Date of Issue** | **Reasons** |
| 1 | CAHSC 402 | 01 | 02 | May 2019  (2 May 2019) | * Revision table changed to document change history * PAN no. added * Scope format modified * Fire NOC or equivalent, as applicable added * Fee structure changed (application fee and 2 years certification fee to be taken in advance as one payment instead of annual payment), Sl. no. 21 modified accordingly |
| 2 | CAHSC 402 | 02 | 03 | August 2019  (20 August 2019) | * Removed the fee structure * Terms and conditions of maintaining accreditation line edited i.e. certification is added |
| 3 | CAHSC 402 | 03 | 04 | March 2021  (20 March 2021) | * Changed word organisation to facility. * Goods and Services Tax (GST) and MSME Registration clause added (6 and 7) * Edited clause 3 and 9 * HCF added in point 2 of clause 25 * Added date under authorised signatory |
| 4 | CAHSC 402 | 04 | 05 | January 2023 (05 January 2023) | * Health Care Facility/HCF is replaced with Hospitals. |
| 5 |  |  |  |  |  |

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

1. Quality & Accreditation Institute (QAI)’s Centre for Accreditation of Health & Social Care (**CAHSC**) offers certification services to Hospitals.
2. Application shall be made in the prescribed form QAI CAHSC 402 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 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 401 Information Brochure for Certification of Hospitals 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. **Applying for (please tick the relevant)**
   1. **First certification\* □**

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

* 1. **Renewal of certification □**

**Date of 1st certification ….……………**

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

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1. **Contact Details of the Hospital:**
2. **Address**-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Website**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Contact No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **E-mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **Ownership:**

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

1. **Legal Identity of the organisation with the date of registration**

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

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

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

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

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

1. **Name of the Parent Organisation, if part of a bigger organisation**

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

Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

1. **Contact person(s):**
2. **Senior Management in the Hospital**

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

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

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

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

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

* 1. **Person Coordinating with QAI:**

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

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

Tel./ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Information of Hospital and Services:**
2. **Total no. of beds that have been sanctioned:**
3. **Total no. 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) |  |

**c. 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 5 most frequent clinical diagnosis for in-patients:**
   1. ……………………………
   2. ……………………………
   3. ……………………………
   4. ……………………………
   5. ……………………………
3. **List 5 most frequent surgical procedures done for in-patients**
4. ……………………………
5. ……………………………
6. ……………………………
7. ……………………………
8. ……………………………
9. **Scope of Certification –Clinical Specialities in the HCF:**

|  |  |  |
| --- | --- | --- |
| **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 Certification- Diagnostic Services in the Hospital (mention Yes/ No):**

**(ONLY IN HOUSE SERVICES WILL BE INCLUDED IN THE CERTIFICATION)**

|  |  |  |
| --- | --- | --- |
| **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 Certification - Clinical Support departments/services in the Hospital (mention Yes/ No) (ONLY IN HOUSE SERVICES WILL BE INCLUDED IN THE CERTIFICATION)**

|  |  |  |
| --- | --- | --- |
| **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 following mandatory Statutory/ Regulatory requirements the Hospital 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)** |  |  |  |
| **Bio-medical Waste Management and Handling Authorisation** |  |  |  |
| **License for MTP** |  |  |  |
| **License for PNDT** |  |  |  |
| **Registration With Local Authorities** |  |  |  |
| **Fire NOC or equivalent, 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. **Litigation, if any:**
2. **Date of last self-assessment:**­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Date of implementation of QAI standards:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **Application Fees and Certification Fees**

Application fees \_ Certification 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 Hospital standards.
* We agree to comply with certification 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 certification.
* 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

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