**QAI CAHSC 1302**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**ACCREDITATION OF EMERGENCY DEPARTMENT**

**Issue No.: 02 Issue Date: March 2024**

**CHANGE HISTORY**

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| **Sl. No.** | **Doc No.** | **Current Issue No.** | **New Issue No.** | **Date of Issue** | **Reasons** |
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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 service to Emergency Department.
2. Application shall be made in the prescribed form QAI CAHSC 1302 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 Maintaining QAI 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 familiarize itself with QAI CAHSC 002 ‘General Information Brochure, QAI CAHSC 1301 Information Brochure for Emergency Department’ 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 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. **Accreditation\* □**

**\*** (Facility is advised to implement the standards for at least 2 months

before applying)

* 1. **Re-accreditation □**

**Date of 1st Accreditation ……………**

1. **Name of the Facility:** (the same shall appear on the accreditation certificate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Contact Details of Organisation:**
3. **Address**-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Website**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Contact No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **E-mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **Ownership:**

|  |  |
| --- | --- |
| **□**Private – Corporate | **□**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** (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. **Name of the Parent Organisation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

Tel./ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **Human Resource:**
**a. Details of the staff**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Name** | **Designation** | **Academic and Professional Qualifications\*** | **Total experience (in years)** | **Experience in Emergency Department**  |
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\* Please clearly indicate the field of specialisation

**b. 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. **Size of the hospital:**
2. Total no. of operational beds that have been sanctioned:
3. Total no. of emergency beds currently in operation:

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

Furnish details of 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 |  |  |  |
| Bio-medical Waste Management and Handling Authorisation |  |  |  |
| License for MTP |  |  |  |
| License for PNDT |  |  |  |
| Fire NOC, as applicable |  |  |  |
| **Registration for all Modalities from AERB:** |
| License to operate Radiation emitting equipment (e.g. X-Ray, CT etc.) |  |  |  |

1. **Litigation, if any:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Date of last Self-assessment:**­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of implementation of QAI standards:** \_\_\_\_\_\_\_\_\_\_\_\_\_

 (Organisation 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/ Transaction ID\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Date Application Completed:** \_\_\_\_\_\_\_\_\_ Day \_\_\_\_\_\_\_ Month \_\_\_\_\_\_\_\_Year
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 Emergency Department 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 organisation.
* 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