**QAI CAHSC 1502**

**Quality and Accreditation Institute**

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



**Change Adapt Improve**

**Application Form**

**for**

**Accreditation of Small Hospitals**

**Issue No.: 01 Issue Date: October 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 Small Hospitals (SH).
2. Application shall be made in the prescribed form QAI CAHSC QAI CAHSC 1502 only. Application form can be downloaded from website as a word file. Applicant SH 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 SH shall provide soft-copy of appropriate document(s) in support of the information being provided in this application form.
3. SH is advised to familiarize itself with QAI CAHSC 002 ‘General Information Brochure’, QAI CAHSC 1502 ‘Information Brochure for Accreditation of Small Hospitals’ and QAI CAHSC 003 ‘Terms and Conditions for Maintaining Accreditation/ Certification’ before filling up this form.
4. The applicant SH 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\* □**

**\*** *(Small Hospital 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 Small Hospital (SH):** (the same shall appear on the certificate)

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

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

**Address**

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

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

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

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

**Website*:***

1. **Ownership:**

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

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

 (If the SH is part of a bigger organisation)

Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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. **Legal identity of the SH 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 SH**

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

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

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

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

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

* **Person Coordinating with QAI:**

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

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

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

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

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

1. **Information of SH 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)
 |  |

1. **Number of OTs:**

**General: Super-speciality:**

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

1. **Does the SH 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 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 following mandatory Statutory/ Regulatory requirements the SH 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 Authorization** |  |  |  |
| **Registration with Local Authorities** |  |  |  |
| **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:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(SH is advised to 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 requirements of the standards for the accreditation of the SH.
* 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 SH that are part of the scope of accreditation.
* We undertake to satisfy all national, regional and local regulatory requirements for operating the SH.
* 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

A-34, Sector 48, Noida-201304, India

Website: www.qai.org.in

Twitter: @QAI2017