**QAI CAHSC 702D**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**AMBULATORY CARE FACILITY-DENTAL**

**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 702D | 01 | 02 | March 2021  (20 March 2021) | * City added in point 2 of clause 3. * Changed word organisation to facility. * 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 702D 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 701D Information Brochure for Ambulatory Care Facility- Dental’ 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-Dental 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 Ambulatory Care Facility-Dental (ACFD):** (the same shall appear on the certificate)

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

**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 ACFD 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):

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1. **Legal identity of the Ambulatory Care Facility-Dental 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-Dental:**

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

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

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

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

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

* **Person Coordinating with QAI:**

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

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

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

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

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

1. **Information of Facilities and Services:**
2. **Total no. of beds that have been sanctioned (If any):**
3. **Number of OTs, if applicable:**
4. **Type of Dental Facility:**

|  |  |  |
| --- | --- | --- |
| **Number of dental chairs in clinic/ facility without inpatients** | **Please select** | **Number of Dental Chairs** |
| **1-3** |  |  |
| **4-8** |  |  |
| **9-15** |  |  |
| **Without inpatient facility** |  |  |

**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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **List 5 most frequent procedures done for patients**
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **Scope of Accreditation – Clinical Services in Ambulatory Care Facility – Dental**

|  |  |  |  |
| --- | --- | --- | --- |
| SERVICES | **AVAILABILITY OF SERVICE**  **YES/NO** | **SERVICES** | **AVAILABILITY OF SERVICE**  **YES/NO** |
| Anaesthesia Services |  | Oral and Maxillofacial Surgery |  |
| Community Dentistry |  | Oral Pathology |  |
| Conservative Dentistry |  | Pedodontics |  |
| Endodontics |  | Periodontology |  |
| Implant Dentistry |  | Prosthodontics |  |
| Oncology |  | Trauma Care |  |
| Oral Medicine and Radiology |  | Others, please specify |  |
| Orthodontics |  |

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

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

|  |  |  |
| --- | --- | --- |
| **Diagnostic Services** | **In House** | **Out sourced** |
| ***Diagnostic Imaging:*** |  |  |
| IOPA X-Ray |  |  |
| Dental Scan/ Dental CT Scan |  |  |
| Occlusal X- Ray |  |  |
| OPG/ CEPH X-Ray |  |  |
| Other Extraoral X-Rays |  |  |
| ***Laboratory Services:*** |  |  |
| Clinical Bio-chemistry |  |  |
| Clinical Microbiology and Serology |  |  |
| Clinical Pathology |  |  |
| Haematology |  |  |
| Histopathology / Oral Pathology |  |  |
| ***Dental Lab Services:*** |  |  |
| Dentures |  |  |
| Crown and Bridge |  |  |
| Implant Prosthesis |  |  |
| Any other |  |  |
| ***Other Diagnostic Service (s):*** |  |  |

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 |  |  |
| Housekeeping |  |  |
| Information Technology |  |  |
| Laundry |  |  |
| Maintenance/Facility Management |  |  |
| Management of Bio-medical Waste |  |  |
| Pharmacy |  |  |
| Security |  |  |
| Supply Chain Management/  Material Management |  |  |
| Other, please specify |  |  |

1. **List of Major Equipment (Please list major equipment available)**

|  |  |  |
| --- | --- | --- |
| **Sl. No.** | **Name of Equipment** | **Identification Number** |
|  |  |  |
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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:* | | | |
| 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-Dental 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. **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