**QAI CAHSC 1702**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**Application Form**

**for**

**Accreditation of Healthcare Facility as per QAI 7101*Plus***

(Based on ISO 7101:2023)

**Issue No.: 01 Issue Date: May 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 services to Hospitals.
2. Application shall be made in the prescribed form QAI CAHSC 1702 only. Application form can be downloaded from website as a word file. Applicant Health Care Facility (HCF) 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 HCF shall provide soft-copy of appropriate document(s) in support of the information being provided in this application form.
3. HCF is advised to familiarize itself with QAI CAHSC 002 ‘General Information Brochure’, QAI CAHSC 1701 ‘Information Brochure for Accreditation as per QAI 7101Plus‘ and QAI CAHSC 003 ‘Terms and Conditions for Maintaining Accreditation/ Certification’ before filling up this form.
4. The applicant HCF 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. **Type of HCF:** ---------------------------------------------------------------------------------------------
2. **Name of the HCF:** (the same shall appear on the certificate)

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

**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 HCF 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):
2. **Micro, Small and Medium Enterprises (MSME) Registration Number** (Please attach a copy of Registration Certificate, if applicable):­­­­­­
3. **Legal identity of the HCF 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):
4. **Contact person(s):**
* **Head of the HCF**

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

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

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

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

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

* **Person Coordinating with QAI:**

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

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

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

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

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

1. **Information of HCF:**
2. **Type of healthcare facility (health system/hospital/clinic etc.):**
3. **Total number of sanctioned beds, if applicable:**
4. **Total number of beds currently in operation:**

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

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sl. No. | Name | Designation | Academic and Professional Qualifications\* | Total Experience (in years) | Experience in Stroke Care Centre |
|   |  |  |  |  |  |
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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. **Statutory/ Regulatory/ Legal Compliance**

Furnish details of the following mandatory Statutory/ Regulatory requirements as applicable to the HCF (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 7101Plus standard:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(HCF 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.
* 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