**QAI CAHSC 2102**

**Quality and Accreditation Institute**

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



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**ACCREDITATION OF**

**HEMATOPOIETIC CELL TRANSPLANTATION**

**AND CELLULAR THERAPY (HCT)**

**Product Collection, Processing, and Administration**

**Issue No.: 01 Issue Date: June 2025**

**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 Hematopoietic Cell Transplantation and Cellular Therapy (HCT)- Product Collection, Processing, and Administration
2. Application shall be made in the prescribed form QAI CAHSC 2101 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 2101 ‘Information Brochure for Hematopoietic Cell Transplantation and Cellular Therapy (HCT) 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\* □**

**\*** (HCT 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 HCT Facility:** (the same shall appear on the accreditation certificate)

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

1. **Contact Details of Centre:**
2. **Address**: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Website**: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Contact No:** \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **E-mail:** \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **Type of Organisation & Legal Identity:**

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

1. **Legal Identity Registration Details** (Please attach the certificate)

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

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):** 
   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:**  
   1. **Details of Human Resource for HCT Activities**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sl. No. | Name | Designation | Academic and Professional Qualifications\* | Total Experience (in years) | Experience in HCT |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |

\* Please clearly indicate the field of specialisation

* 1. **Staff Information for HCT Activities:**

| **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. **Number of beds in HCT Unit:**
2. **Number of Transplantation/ Cellular Therapy Conducted in last three years:**

Year 1:

Year 2:

Year 3:

1. **Scope of Accreditation: Type of Facility**

| **Sl. No.** | **Types of Hematopoietic Cell Transplantation and Cellular Therapy (HCT) Facilities** | **Service Provided**  **(YES or NO)** |
| --- | --- | --- |
|  | Administration |  |
|  | Collection, administration |  |
|  | Collection, processing, administration |  |
|  | Collection, storage, administration |  |
|  | Processing, storage, distribution |  |
|  | Collection, processing, storage, administration |  |
|  | Collection and distribution (for administration or to processing facility) |  |
|  | Manufacturing, storage, distribution |  |
|  | Collection, processing, storage, distribution, administration |  |
|  | Collection, processing, manufacturing, storage, distribution, administration |  |

1. **Scope of Accreditation: Type of Cells**

| **Sl. No.** | **Types of Cells** | **Service Provided**  **(YES or NO)** |
| --- | --- | --- |
|  | Hematopoietic progenitor cells (HPCs) |  |
|  | Nucleated cells or mononuclear cells from any hematopoietic tissue source |  |
|  | Immune effector cells (IECs) |  |
|  | Genetically modified cells |  |

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 Up to** | **Remarks**  (Related to renewal/ in process) |
| --- | --- | --- | --- |
| Registration Under Clinical Establishment Act (or similar) |  |  |  |
| Registration With Local Authorities (if applicable) |  |  |  |
| Bio-medical Waste Management and Handling Authorisation |  |  |  |
| License under NDPS |  |  |  |
| License for Blood bank, as applicable |  |  |  |
| Fire NOC, as applicable |  |  |  |
| Any other, as applicable |  |  |  |
| **Registration for all Modalities from AERB:** | | | |
| License to operate Radiation emitting equipment (Irradiation facility etc.) |  |  |  |

1. **Information on Litigation, if any:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Date of last Self-assessment:**­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Date of implementation of QAI standards:** \_\_\_\_\_\_\_\_\_\_\_\_\_

(HCT Facility is advised to implement the standards for at least 2 months before applying)

1. **Application Fees**

Application fees (Rs.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank transfer reference number or Transaction ID/ DD or at par cheque number/:

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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 HCT Facility 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

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Email: info@qai.org.in Website: [www.qai.org.in](http://www.qai.org.in)