APPLICATION
For
ACCREDITATION OF HOSPITAL

Issue No.: 01
Issue Date: December 2011

Guidelines for filling the application form

(Please read this carefully before filling this form)

1. Kindly fill the application form in **BLACK INK** only. You can also submit a printed version of the filled application form.
2. **For Sl. No. 2**: Kindly mention if the organisation is a public/ government establishment or an independent/ private sector provider.
3. **For Sl. No. 7**: Please specify e.g. clinical establishment, shop, etc.
4. **For Sl. No. 8**: Please state the number currently in operation. For example, the hospital may have approval for 250 beds but presently if only 100 beds are operational, please mention only 100 (after exclusions mentioned against that point). *However, the hospital shall inform NABH of any increase in operational beds.*
5. **For Sl. No. 10, 11 & 12**:
    a. Please indicate "Yes" only if there are individuals holding recognised degrees managing the department. Please ensure that there are OP services for all the ticked specialities (excluding lab). However, you can include a department not having OP but providing all other care.
    b. Under the column number of consultants mention only consultants (and not resident doctors or fee for service doctors who visit the hospital only when called).Please mention full time and part time consultants separately as X + Y=Z
    c. While filling the row "others" mention only the name of any recognised speciality. Please do not mention services e.g. laparoscopic surgery as departments.
    d. Please note that this list of specialities is based on the recognised medical degrees by the Medical Council of India.
    e. ***If the scope includes any super-speciality then the hospital will not be considered for assessment under SHCO Standards.***
    f. **PLEASE NOTE THAT THE SCOPE OF ACCREDITATION SHALL BE TRANSCRIBED FROM THESE THREE HEADINGS ONLY.** For the sake of uniformity the scope shall mention the specialities using the same terminology.
6. **For Sl. No. 15**: In case of ICU the type of care pertains to nature of service e.g. adult cardiac care unit, neonatal, etc. In case of OT this pertains to speciality/nature e.g. cardio-thoracic, emergency, septic, etc.
7. **For Sl. No. 16**: Type of care pertains to nature of service e.g. adult/paediatric; male/female. Use codes like AM (adult male), AF (adult female), AMF (adult male and female), PM (paediatric male), PF (paediatric female), PMF (paediatric male and female). If there is no categorization please mention as open to all.
8. **For Sl. No. 17**: This pertains to all units which are a part of the hospital e.g. outreach clinics, satellite clinics etc. Under the column type of service kindly mention the speciality and/or super-speciality. If all specialities are covered just mention as "all". *Do not mention camps conducted by hospital.*
9. **For Sl. No. 19**: If a particular license is not required in your region or is not applicable for your set up kindly mention the same in "Remarks" column. You can also use this column to state "applied for" ; "pending approval"; "applied for renewal on…." etc.
10. **For Sl. No. 20**: Provide the information using the example below.

Location	Area/Activity
Ground floor	OPD, Billing, Reception, Laboratory
First floor	OT, ICU

11. ***The hospital shall ensure that it shall send an updated application form to NABH in case of any changes especially before pre-assessment and final assessment.***

1. **Name of the Hospital:**

_____

2. **Address:**

_____

_____

Website (if present):_____

3. **Ownership:**

_____

4. **Year in which established/registered:**

_____

5. **Year in which operations started:**

_____

6. **Contact person(s):**
(Please indicate [√] with whom correspondence to be made)

- Chief Executive Officer: (or equivalent) ☐
  Mr./Ms./Dr. _____
  Designation: _____
  Tel: _____ Mobile: _____
  Fax: _____ E-mail: _____

- Accreditation Coordinator: ☐
  Mr./Ms./Dr. _____
  Designation: _____
  Tel: _____ Mobile: _____
  Tel: _____ Mobile: _____
  Fax: _____ E-mail: _____

7. **Is the Hospital registered with Local Authorities:***(Where applicable as per the State or Central Norms)*

_____

8. **Number of Inpatient Beds:** *(please exclude emergency, day-care, recovery room beds etc.)*

_____

9. OPD and IPD data: *(Hospital shall at least be functioning for 6 months before applying)*

OPD DATA (Past two years, Jan-Dec)

Year	Number of Patients

IPD DATA (Past two years, Jan-Dec)

Year	Number of Patients Admitted

10. Scope of Accreditation (Broad Specialities in the hospital):

Speciality	Service Provided	Number of OPs during the Previous Calendar Year	Number of Consultants
Anaesthesiology	**YES/NO**		
Dermatology and Venereology	**YES/NO**		
Family Medicine	**YES/NO**		
General Medicine	**YES/NO**		
Geriatrics	**YES/NO**		
General Surgery	**YES/NO**		
Laboratory			
➢ **Bio-chemistry**	**YES/NO**	**NA**	
➢ **Microbiology**	**YES/NO**	**NA**	
➢ **Pathology**	**YES/NO**	**NA**	
➢ **Immuno-haematology**	**YES/NO**	**NA**	
➢ **Medical Genetics**	**YES/NO**	**NA**	
Nuclear Medicine	**YES/NO**		
Obstetrics and Gynaecology	**YES/NO**		
Ophthalmology	**YES/NO**		
Orthopaedic Surgery	**YES/NO**		

Otorhinolaryngology	**YES/NO**		
Paediatrics	**YES/NO**		
Psychiatry	**YES/NO**		
Radiation Oncology	**YES/NO**		
Radiology	**YES/NO**		
Respiratory Medicine	**YES/NO**		
Sports Medicine	**YES/NO**		
Others, please state	**YES/NO**		

11. Scope of Accreditation (Super Specialities in the hospital):

Speciality	Service Provided	Number of OPs during the Previous Calendar Year	Number of Consultants
Cardiac Anaesthesia	**YES/NO**		
Cardiology	**YES/NO**		
Cardiothoracic Surgery	**YES/NO**		
Clinical Haematology	**YES/NO**		
Endocrinology	**YES/NO**		
Hepatology	**YES/NO**		
Hepato-Pancreato-Biliary Surgery	**YES/NO**		
Immunology	**YES/NO**		
Medical Gastroenterology	**YES/NO**		
Neonatology	**YES/NO**		
Nephrology	**YES/NO**		
Neurology	**YES/NO**		
Neurosurgery	**YES/NO**		
Oncology			
➢ **Medical Oncology**	**YES/NO**		
➢ **Gynaecological Oncology**	**YES/NO**		
➢ **Surgical Oncology**	**YES/NO**		
Paediatric Gastroenterology	**YES/NO**		
Paediatric Cardiology	**YES/NO**		

Paediatric Cardio-Thoracic Vascular Surgery	**YES/NO**		
Paediatric Surgery	**YES/NO**		
Plastic and Reconstructive Surgery	**YES/NO**		
Neuro-Radiology	**YES/NO**		
Rheumatology	**YES/NO**		
Surgical Gastroenterology	**YES/NO**		
Urology	**YES/NO**		
Vascular Surgery	**YES/NO**		
Others, please state	**YES/NO**		

12. Scope of Accreditation (Support departments in the hospital):

Professions allied to medicine	**In House**	**Serves other organisation (s)**	**Out sourced**
Dietetics	**YES/NO**	**YES/NO**	**YES/NO**
Rehabilitation			
➢ **Occupational Therapy**	**YES/NO**	**YES/NO**	**YES/NO**
➢ **Physiotherapy**	**YES/NO**	**YES/NO**	**YES/NO**
➢ **Speech and Language Therapy**	**YES/NO**	**YES/NO**	**YES/NO**

13. Details of Diagnostic Services being provided by the hospital:

Diagnostic Service	**In House**	**Serves other organisation(s)**	**Out sourced**
Diagnostic Imaging:			
Bone Densitometry	**YES/NO**	**YES/NO**	**YES/NO**
CT Scanning	**YES/NO**	**YES/NO**	**YES/NO**
DSA Lab	**YES/NO**	**YES/NO**	**YES/NO**
Gamma Camera	**YES/NO**	**YES/NO**	**YES/NO**
Mammography	**YES/NO**	**YES/NO**	**YES/NO**
MRI	**YES/NO**	**YES/NO**	**YES/NO**
PET	**YES/NO**	**YES/NO**	**YES/NO**
Ultrasound	**YES/NO**	**YES/NO**	**YES/NO**

X-Ray	**YES/NO**	**YES/NO**	**YES/NO**
Laboratory Services:			
Blood Transfusion services	**YES/NO**	**YES/NO**	**YES/NO**
Clinical Bio-chemistry	**YES/NO**	**YES/NO**	**YES/NO**
Clinical Microbiology and Serology	**YES/NO**	**YES/NO**	**YES/NO**
Clinical Pathology	**YES/NO**	**YES/NO**	**YES/NO**
Cytopathology	**YES/NO**	**YES/NO**	**YES/NO**
Haematology	**YES/NO**	**YES/NO**	**YES/NO**
Histopathology	**YES/NO**	**YES/NO**	**YES/NO**
Genetics	**YES/NO**	**YES/NO**	**YES/NO**
Molecular Biology	**YES/NO**	**YES/NO**	**YES/NO**
Toxicology	**YES/NO**	**YES/NO**	**YES/NO**
Other Diagnostic Services:			
2D Echo	**YES/NO**	**YES/NO**	**YES/NO**
Audiometry	**YES/NO**	**YES/NO**	**YES/NO**
EEG	**YES/NO**	**YES/NO**	**YES/NO**
EMG/EP	**YES/NO**	**YES/NO**	**YES/NO**
Holter Monitoring	**YES/NO**	**YES/NO**	**YES/NO**
Spirometry	**YES/NO**	**YES/NO**	**YES/NO**
Tread Mill Testing	**YES/NO**	**YES/NO**	**YES/NO**
Urodynamic Studies	**YES/NO**	**YES/NO**	**YES/NO**
Any Other Diagnostic Service (s):			

14. Details of Non Clinical and Administrative departments:

Support Service	In House	Serves other organisation(s)	Out sourced
Ambulance Service	YES/NO	YES/NO	YES/NO
Bio-medical Engineering	YES/NO	YES/NO	YES/NO
Blood Bank	YES/NO	YES/NO	YES/NO
CSSD	YES/NO	YES/NO	YES/NO
Catering	YES/NO	YES/NO	YES/NO
General Administration	YES/NO	YES/NO	YES/NO
Housekeeping	YES/NO	YES/NO	YES/NO
Human Resources	YES/NO	YES/NO	YES/NO
Information Technology	YES/NO	YES/NO	YES/NO
Laundry	YES/NO	YES/NO	YES/NO
Maintenance/Facility Management	YES/NO	YES/NO	YES/NO
Management of Bio-medical Waste	YES/NO	YES/NO	YES/NO
Mortuary Services	YES/NO	YES/NO	YES/NO
Pharmacy	YES/NO	YES/NO	YES/NO
Security	YES/NO	YES/NO	YES/NO
Social Service	YES/NO	YES/NO	YES/NO
Supply Chain Management/ Material Management	YES/NO	YES/NO	YES/NO
Other, please specify	YES/NO	YES/NO	YES/NO

15. List Emergency, ICU and OT areas: (append list as annexure in the below mentioned format if multiple such areas exist)

Name of Unit/ Ward	Number of Beds	Type of Care Given	Floor/ Location
Emergency			
ICU			
OT			

16. List Inpatient Care Units/ Wards, the Number and The type of care given in each Unit/ Ward:

Name of Unit/ Ward	Number of Beds	Type of Care Given	Floor/ Location

17. List Ambulatory/ Out Patients Units, the number of visits and the Type of Service:

Name of Ambulatory/ Out Patient Unit of Clinic	Average Visits per month	Type of Service

- **Are these included in the scope of accreditation? YES/NO**

18. Staff Information:

Group	Number	Remarks if any
Managerial		
Doctors*		
➢ **Resident Doctors**		
➢ **Consultants**		
a) Full Time		
b) Part Time		
Allied Medical Speciality Staff*		
Nurses		
Technicians		
Housekeeping staff		
Others		

*Append the list of staff

*Refer to serial number 12 for information on who need to be included

19. **Furnish details of applicable Statutory/ Regulatory requirements the organisation is governed by*:**

License/Certificate	Number and Date	Valid Upto	Remarks (if any)
General:			
Bio-medical Waste Management and Handling Authorization			
Employee Provident Fund			
Employee State Insurance			
PAN			
Registration Under Clinical Establishment Act (or similar)			
Registration With Local Authorities			
Facility management:			
Building Occupancy / Completion Certificate			
Fire (NOC)			
License for Diesel Storage			
License for Electrical Installations			
License to Store Compressed Gas			
Registration for Boiler			
Sanction for Lifts			
Radiology:			
X-ray (including portable and cath lab)			
CT Scan Machine			
PNDT Act Registration			
Clinical departments:			
Blood bank			
License for MTP			
Transplantation Registration			

Nuclear Medicine and Radiation therapy:			
Authorization to Treat Thyroid Cancer Patients Using I-131			
Authorization to Use Radiopharmaceuticals in Humans			
Consent for Use of Radioisotopes in Nuclear Medicine			
License for Nuclear Medicine			
Approval of Room Layout Plan for Radiation Therapy Facilities			
Authorization to Procure Radiation Sources for Radiation Therapy			
Pharmacy ***(if over multiple locations license for each of them separately)***			
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:			

Please submit scanned copies of all the statutory requirements while submitting the documents

20. Layout/Geographical Distribution

Location	Area/Activity

21. Litigation, if any:

_____

22. Date of last Self-assessment: _____

23. Date of Implementation of NABH standards: _____
(Hospital shall apply at least 3 months after implementing NABH standards)

24. Terms and Conditions for maintaining NABH accreditation submitted: Yes No

25. Date Application Completed: _____ Day _____ Month _____Year

_____
Authorised Signatory (CEO or equivalent)

Name: _____

Designation: _____