Form
.....VI.....

ORIGINAL

REPUBLIC OF KENYA

THE MEDICAL PRACTITIONERS AND DENTISTS ACT

(Cap. 253)

APPLICATION FOR REGISTRATION OF A HEALTH INSTITUTION

PROCESS FOR REGISTRATION OF A NEW HEALTH FACILITY

a Submission of the Application Form together with the required documents;

b Verification of the following submitted documents;

- Inspection Report from the County;
- Certificate of Registration as a business;
- Copy of Directors' ID; and
- Copies of degree certificates/ diploma, certificates of registration from respective Regulatory Bodies, current licences
- Certified Copy of employment contract for each health care provider listed in the application form;
- An Environmental compliance report from NEMA
- Requisite payment;

Approval for registration as a health facility based on the above verification process;

1. Data entry of the new facilities details in the KMPDC system;
2. Issuing of KMPDC facility registration number and certificate;
3. Issuing of KMPDC facility operating license;
4. Dispatching of certificates and licenses;

NOTE: ***This process takes a minimum of two (2) weeks.***

PART 1

To be completed by the applicant

1 CONTACT DETAILS OF THE PROPOSED INSTITUTION

(Block Letters)

a) NAME OF THE HEALTH INSTITUTION.....……

b) POSTAL ADDRESS…….……...

c) TELEPHONE NUMBER……MOBILE…….……..……

d) EMAIL ADDRESS..... . ...

2 ALL TYPE (Dental Clinic , Dispensary ,Faith Based, Dispensary , Mobile Clinic , Eye Clinic , Faith Based Basic Health Centre, Basic Health Centre , Faith Based Comprehensive Health Centre , Comprehensive Health , Medical/Dental Centre , Funeral Home Stand Alone , Maternity Home , Nursing Home/Cottage Hospital , Faith Based Level 4 Hospital , Hospital Level 4/ Internship Training Centre/County Hospital , Faith Based Hospital Level 5 , Hospital Level 5/ County Referral Hospitals , Faith Based Specialized Tertiary Referral Hospital , Specialized Tertiary Referral Hospital , Faith Based National Referral and Teaching Hospitals and specialized hospitals Level 6 , National Referral and Teaching Hospitals and specialized hospitals Level 6).

....

....

3 LOCATION OF THE HEALTH INSTITUTION

a) Town/Centre/Market..... .....

....

b) Location..... .....

c) County..... ....

PART II

(To be completed by the applicant)

1 FULL NAMES AND ADDRESS OF THE APPLICANT

(Block Letters)

.....

....

2 STATE IF APPLICANT IS A DIRECTOR AND/OR ADMINISTRATOR OF THE HEALTH INSTITUTION

.....

** Delete where inapplicable*

3 NATIONALITY OF THE APPLICANT

.....

4. PLACE AND DATE OF BIRTH.....

....

5. KENYA NATIONAL ID CARD No.....

(Attach certified Photocopy)

6. PASSPORT No. (*if applicable*)……..

7. EMAIL ADDRESS..... .....

8. WORK PERMIT No. (if applicable)

.....

(Attach documentary evidence-certified copies only).

PART III

(To be completed by the applicant)

Give full names of Directors of the institution including the following: Nationalities, Passport Numbers, Work Permit Numbers, Email Address, Kenya National Identity Card Numbers and profession etc.

(Attach certified copies of documentary evidence).

i NAME OF THE DIRECTOR …….

NATIONALITY……..

PROFESSION…….

PASSPORT NO./ID NUMBER …….

WORK PERMIT NUMBER……...…….

EMAIL ADDRESS……..……

P.O BOX ……...…….

ii NAME OF THE DIRECTOR …….

NATIONALITY……..

PROFESSION…….

PASSPORT NO./ID NUMBER …….

WORK PERMIT NUMBER……...…….

EMAIL ADDRESS……..……

P.O BOX ……...…….

iii NAME OF THE DIRECTOR …….

NATIONALITY……..

PROFESSION…….

PASSPORT NO./ID NUMBER …….

WORK PERMIT NUMBER……...…….

EMAIL ADDRESS……..……

P.O BOX ……...…….

(Use extra space if necessary).

PART IV

(To be completed by the applicant)

1 Give full names and registration number of the medical / dental practitioner or oral health officer who shall be in-charge of the health Institution.(The practitioner must have attained 3 years of experience)

FULL NAMES……..…

REGISTRATION NUMBER ……

2 a) Give full details of professional qualifications of the person named at paragraph (1) of PART IV above. Include year and place where obtained.

……

……

b State work experience of the person named at paragraph (1) of PART IV above and name institutions where obtained and date.

……

……

b.d Attach documentary evidence (certified photocopies) in each case. (Please use extra space if necessary).

3 (a) Give full names and professional qualifications of any other person(s), identified by your institution to undertake patient health care at the institution (e.g., Clinical Officers, Nurses, oral health officers, Laboratory Technicians, X-ray Staff, Doctors, Technicians, Pharmaceutical Technicians, etc.).

i FULL NAMES……

PROFESSIONAL QUALIFICATIONS……

ID NUMBER…….

REGISTRATION NUMBER (**from Regulatory Authority**) ……

CURRENT PRACTICING LICENCE NUMBER…….

ii FULL NAMES……

PROFESSIONAL QUALIFICATIONS……

ID NUMBER…….

REGISTRATION NUMBER (**from Regulatory Authority**) ……

CURRENT PRACTICING LICENCE NUMBER…….

iii FULL NAMES……

PROFESSIONAL QUALIFICATIONS……

ID NUMBER…….

REGISTRATION NUMBER (**from Regulatory Authority**) ……

CURRENT PRACTICING LICENCE NUMBER…….

iv FULL NAMES……

PROFESSIONAL QUALIFICATIONS……

ID NUMBER…….

REGISTRATION NUMBER (**from Regulatory Authority**) ……

CURRENT PRACTICING LICENCE NUMBER…….

v FULL NAMES……

PROFESSIONAL QUALIFICATIONS……

ID NUMBER…….

REGISTRATION NUMBER (**from Regulatory Authority**) ……

CURRENT PRACTICING LICENCE NUMBER…….

vi FULL NAMES……

PROFESSIONAL QUALIFICATIONS……

ID NUMBER…….

REGISTRATION NUMBER (**from Regulatory Authority**) ……

CURRENT PRACTICING LICENCE NUMBER…….

vii FULL NAMES……

PROFESSIONAL QUALIFICATIONS……

ID NUMBER…….

REGISTRATION NUMBER (**from Regulatory Authority**) ……

CURRENT PRACTICING LICENCE NUMBER…….

b Attach certified documentary evidence (**certified photocopies**) in each case. (Please use extra space if necessary).

PART V

(To be completed by Medical Officer of Health)

INSPECTION REPORT FOR HEALTH INSTITUTIONS- FOR REGISTRATION PURPOSES

1. **NAME OF THE INSTITUTION**……

……

2 PHYSICAL LOCATION

(a) Plot No./L.R. No…….....

(b) Market/Centre/Town*……..…

(c) Street / Road..... ....

(d) Location..... ....

(e) County..... .....

3 PREMISES GENERAL INFORMARION

(a) Plot area (in hectares)..... ....

b.b Water supply..... adequate/inadequate*

b.c Refuse disposal

c.i Incinerator available/Not available.*

c.ii Other modes of refuse disposal

(Specify)

.....

.....

b.d Environmental suitability .....recommended/ not recommended.* State reasons for not recommending:

....

....

....

....

4 PLAN OF THE INSTITUTION

a Approved/ No approved* by the local County Development Committee (attach copy of the plan) and documentary evidence (copies) of approval of the institution by the D.D.C

3.5 OUT -PATIENT SERVICES

(See attached minimum requirements for General Practice).

*5.a Waiting Bay/ Reception Area/Room: **

a.i Seating capacity.....

a.ii Area (in square meters).....

a.iii Construction.....Covered/ Not Covered. *

** Delete where inapplicable.*

5.b Examination Rooms:

i Number of rooms.....

ii State if equipment inspected meets the minimum requirements. Attach separate signed list of equipment inspected if necessary.

.....

.....

.....

.....

.....

iii Treatment room:

a Number of rooms.....

b State if equipment meets the minimum requirements. Attach separate signed list of equipment inspected.

3.6 IN-PATIENT SERVICES

6.a Female Ward:

i Size of the ward (in square metres).....

ii Number of beds.....

iii Number of toilets.....

iv Number of bathrooms.....

v Number of sluice rooms.....

6.b Male Ward:

i Size of the ward (in square metres).....

ii Number of beds.....

iii Numberoftoilets.....

iv Number of bathrooms.....

v Number of sluice rooms.....

6.c Maternity Ward:

i Size of the ward (in square metres).....

ii Number of beds.....

iii Numberoftoilets.....

iv Number of bathrooms.....

v Number of sluice rooms.....

vi Placenta pit depth (in meters).....

6.d Paediatric Ward:

i Size of the ward (in square metres).....

ii Number of beds.....

iii Numberoftoilets.....

iv Number of bathrooms.....

v Number of sluice rooms.....

3.7 CLINICAL SUPPORT SERVICES

7.a Pharmacy:

i Area of the waiting room (in square metres).....

ii Number of dispensing windows.....

iii Number of antibiotic (safe cupboards.....

iv Number of drug stores.....

7.b Laboratory: (see attached minimum requirements)

i Reception area (in square metres).....

ii Seating capacity..... ....

iii Size of work-room (in square metres).....

iv Equipment (attach a separate signed list of equipment and reagents/chemicals inspected).

7.c X- ray Unit: (See attached minimum requirements).

.i Size of the reception area (in square metres).....

.ii Seating capacity..... .....

.iii Number screening rooms.....

.iv Standard of radiation protection..... .....
Adequate/Not Adequate. *

.v Equipment (attach separate signed list of equipment inspected).

7.d Operating Theatre:

d.i Minor theatre equipment (attach separate signed list of equipment inspected).

d.ii Major theatre (indicate by a tick or cross in the box next to the item to show whether available or not).

Induction room..... ☐

Operating room..... ☐

Recovery room..... ☐

Lighting ..... (Adequate/Not Adequate).*

Equipment. ..... (attach separate signed list of equipment inspected).

3.8 OTHER SUPPORTING SERVICES

a Kitchen

a.i Cooking facility

(specify) .....(ii)

Non-Perishable store.....(Adequate/Not Adequate).* (iii)

Perishable store.....(Adequate/Not Adequate).*

(b) *Laundry Type (specify).....* .

....

c Mortuary:

c.i Available/ Not Available.*

c.ii Refrigerated/ Not refrigerated.*

c.iii Appropriately located /Not appropriately located.*

If not appropriately located, state why..... .....

.....

(iv) Body capacity..... .....

(v) Adequate Privacy /Not Adequate Privacy.*

(vi) Number of ambulances..... ....

(vii) Other facility (specify and use extra space if necessary .....

** Delete where inapplicable*

PART VI

(To be completed by the Medical /Dental /Oral Health Officer of Health)

1 Give full names and designations of members of the C.H.M.T and KMPDC team who participated in the inspection of the institution.

NAME	DESIGNATION

NOTE: The inspection team to state the recommended level of the facility

PART VII

(The applicant to sign in witness of the inspection team)

I, Dr. /Mr. /Mrs. /Miss *..... .....

(Full Names in Block Letters)

hereby certify that all the information given by me in the application form is true and correct and that I personally witnessed the inspection which was conducted by the Medical /Dental / Oral Health Officer of Health and KMPDC on

.....day of ....., 20.....

Signature.....

INSTRUCTIONS TO THE DIRECTOR REGISTRATION AND LICENSING

.....

.....

.....

.....

Dated this.....day of .....,20……...

.

.....

Deputy Director

Health and Training Institution, Compliance

INSTRUCTIONS TO THE REGISTRAR OF KMPDC

.....

.....

.....

.....

Dated this.....day of .....,20……...

.

.....

Director

Registration and Licensing

GPK