REPUBLIC OF KENYA

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

FORM – XX

KMPDC Complex, Woodlands Road, off Lenana Road
P.O. Box 44839 – 00100, Nairobi
+254 727 666 444 | +254 111 052 222
info@kmpdc.go.ke | www.kmpdc.go.ke

APPLICATION FOR ACCREDITATION AS A CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PROVIDER

PURSUANT TO THE MEDICAL PRACTITIONERS AND DENTISTS ACT (CAP 253 – LAWS OF KENYA)

A. ADMINISTRATIVE INFORMATION

THE APPLICATION FORM MUST BE COMPLETED BY A DULY AUTHORIZED PERSON

DETAILS OF THE PROPOSED PROVIDER

NAME OF INSTITUTION			
NAME OF HEAD OF INSTITUTION OR DEPARTMENT			
NAME OF CPD COORDINATOR			
TYPE OF ORGANIZATION			
PHYSICAL ADDRESS			
CITY/TOWN			
COUNTY			
POSTAL ADDRESS			
POSTAL CODE			
PLOT NUMBER		LR NUMBER	
MOBILE NUMBER			
E-MAIL ADDRESS			
WEBSITE			

CONTACT PERSONS

NAME	
DESIGNATION	

MOBILE NUMBER	
E-MAIL ADDRESS	
ALTERNATE'S NAME	
ALTERNATE'S MOBILE NUMBER	

B. REQUIREMENTS

1. CERTIFICATE OF INCORPORATION
2. COVER LETTER; EXPLICITLY REQUESTING TO BE A CPD PROVIDER, SHOULD STATE DETAILS OF THE PROVIDER ORGANISATION/ INSTITUTION AND BRIEF DETAILS ON QUALIFICATIONS AND EXPERIENCES WITH CPD DELIVERY AND THEIR COMMITMENT TO QUALITY
3. PROPOSED CALENDAR OF ACTIVITIES FOR THE YEAR
4. RECOMMENDATION LETTERS FROM AT LEAST 2 REFEREES AND THEIR CURRICULUM VITAE
5. EVIDENCE OF CAPACITY TO SUPPORT CPD ACTIVITIES, INCLUDING BUT NOT LIMITED TO:
    a. INFRASTRUCTURE AND EQUIPMENT TO SUPPORT THE PREFERRED MODE OF CPD DELIVERY E.G.: training room or resource centre, internet connectivity (at least 35mbps), online platform, equipment for use during practical sessions
    b. PERSONNEL: evidence of appointment/ engagement/ recruitment/ retention of trainers, who should be specialists or have expertise in the field of practice, evidence of appointment of a CPD coordinator (giving full contact information), for international speakers, providers must validate the licensing status prior to provision of the CPD activity
    c. MODE OF ASSESSMENT OF PARTICIPANTS/FEEDBACK
6. TESTIMONIALS FROM TWO REFEREES, WHO MUST BE MEDICAL, DENTAL OR ORAL HEALTH PRACTITIONERS
7. ETHICAL GUIDELINES SIGNED BY THE APPROPRIATE AUTHORITY ADDRESSING CONFLICT OF INTEREST AND PATIENT CONFIDENTIALITY.
8. QUALITY ASSURANCE IMPROVEMENT POLICY AND PLAN
9. FULL DISCLOSURE ON SPONSORSHIP AND SUPPORT
10. EVIDENCE OF PARTNERSHIP AGREEMENTS FOR CPD DELIVERY, where available.
11. OFFICIAL CONTACT DETAILS OF THE CPD PROVIDER
12. DETAILS OF ONE DESIGNATED CONTACT PERSON

PAYMENT CONFIRMATION	OFFICIAL STAMP
EVIDENCE OF PAYMENT FOR ACCREDITATION AS A CPD PROVIDER KSH. 15,000 (NON-REFUNDABLE) ALL PAYMENTS SHOULD BE MADE ON E-CITIZEN VIA SYSTEM GENERATED INVOICE NUMBER	

C. DECLARATION BY APPLICANT

BY SUBMITTING THE ABOVE INFORMATION HEREBY DECLARE THAT THE ABOVE INFORMATION IS CORRECT AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF

SIGNATURE		DATE	DD	MM	YYYY

FOR OFFICIAL USE

PREPARED BY	CHECKED BY

NAME		NAME	
DESIGNATION		DESIGNATION	
SIGNATURE		SIGNATURE	
DATE		DATE	
REMARKS		REMARKS	

APPROVED/NOT APPROVED					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY