Kenya Medical Practitioners and Dentists Council
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APPLICATION FOR CLOSURE OF HEALTH INSTITUTION

(To be filled by health institution proprietor/director)

SECTION A: FACILITY DETAILS	
Name of Facility:	
Registration Number:	MFL Code:
Health Institution Type/Level:	
Postal Address:	
Physical Location:	
Phone Number:	
SECTION B: PROPRIETOR DETAILS	
Name:	
Designation:	
ID/Passport Number:	
Email Address:	
SECTION C: CLOSURE SECTION	
Effective Date of closure:	
Reason (s) for closure (please provide a detailed explanation):	
SECTION D: PATIENT CARE PLAN	
Continuity of Care for Existing Patients *(Describe the measures in place to ensure the ongoing care of existing patients during and after the closure process)*	

Referral Plan for Ongoing Treatment Cases
(Detail the referral process for patients currently undergoing treatment, including the names of the facilities or practitioners to whom they will be referred)

SECTION D: PATIENT RECORDS MANAGEMENT

Plan for Handling of Patient Records/Information:

Plan for Transfer of Patient Records (if applicable):

SECTION G: DECLARATION

I, the undersigned, hereby declare that the information provided in this application is true and accurate to the best of my knowledge. I acknowledge that providing false information may lead to legal repercussions.

Name of Proprietor/Director: ______________________________ Signature: _______________

Date: ________________________________ Official Stamp:_____________________________

FOR OFFICIAL USE

Received by:	**Confirmed by:**
Name: _____________________	Name: _____________________
Designation:_________________	Designation:_________________
Signature:___________________	Signature:___________________
Date:_______________________	Date:________________________