REPUBLIC OF KENYA

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

FORM – XXI

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APPLICATION FOR CLOSURE OF A HEALTH INSTITUTION

PURSUANT TO THE MEDICAL PRACTITIONERS AND DENTISTS ACT (CAP 253 – LAWS OF KENYA)
TO BE FILLED BY HEALTH INSTITUTION PROPRIETOR/DIRECTOR

A. FACILITY DETAILS	
NAME OF FACILITY	
REGISTRATION NUMBER:	
HEALTH INSTITUTION TYPE/LEVEL	
PHYSICAL ADDRESS	
CITY/TOWN	
COUNTY	
POSTAL ADDRESS	
MOBILE NUMBER	
B. PROPRIETOR DETAILS	
NAME	
DESIGNATION	
MOBILE NUMBER	
E-MAIL ADDRESS	
ID/PASSPORT NUMBER	

C. DETAILS OF CLOSURE			
EFFECTIVE DATE OF CLOSURE	DD	MM	YYYY
REASON (S) FOR CLOSURE (PLEASE PROVIDE A DETAILED EXPLANATION)			

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)	

E. PATIENT RECORDS MANAGEMENT

PLAN FOR HANDLING OF PATIENT RECORDS/INFORMATION	**PLAN FOR TRANSFER OF PATIENT RECORDS (IF APPLICABLE)**

F. DECLARATION BY PROPRIETOR/DIRECTOR

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				
SIGNATURE				OFFICIAL STAMP
DATE	DD	MM	YYYY	

FOR OFFICIAL USE

RECEIVED BY

NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY

CONFIRMED BY

NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY