KMPDC
Enhancing Quality Healthcare

FORM – XIII

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APPLICATION FOR REGISTRATION OF A NEW HEALTH INSTITUTION

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

PROCESS FOR REGISTRATION OF A NEW HEALTH INSTITUTION

A. SUBMISSION OF THE DULY FILLED APPLICATION FORM AND THE FOLLOWING REQUISITE DOCUMENTS

- → SANITATION INSPECTION REPORT FROM THE COUNTY DEPARTMENT OF HEALTH WHICH MUST NOT BE OLDER THAN 6 MONTHS
- → CERTIFIED COPY OF THE CERTIFICATE OF INCORPORATION/TRUSTEE DEED/LETTER FROM COUNTY SECRETARY;(THE REGISTERED NAME OF THE HEALTH INSTITUTION MUST ALIGN WITH THE SERVICES PROVIDED)
- → CERTIFIED COPY OF A VALID CR12 ISSUED WITHIN THE LAST SIX MONTHS
- → CERTIFIED COPY OF DIRECTORS' ID/PASSPORTS
- → CURRENT COLOURED PASSPORT SIZE PHOTOGRAPH OF THE APPLICANT AND DIRECTOR(S)
- → CERTIFIED COPY OF THE APPLICANT ID/PASSPORT WHERE THE APPLICANT IS NOT A DIRECTOR
- → CERTIFIED COPIES OF ACADEMIC AND PROFESSIONAL CERTIFICATES OF ALL MEDICAL PERSONNEL AT THE INSTITUTION
- → CERTIFIED COPIES OF REGISTRATION CERTIFICATE AND CURRENT LICENCES OF ALL MEDICAL PERSONNEL AT THE INSTITUTION FROM RELEVANT REGULATORY BODY
- → CERTIFICATE OF STATUS OF THE OFFICER IN CHARGE OF CLINICAL SERVICES
- → CERTIFIED COPY OF EMPLOYMENT CONTRACT/JOB OFFER FOR EACH HEALTH CARE PROVIDER LISTED IN THE APPLICATION FORM
- → CERTIFIED COPY OF AN ENVIRONMENTAL COMPLIANCE CERTIFICATE FROM NEMA OR A CONTRACT WITH A NEMA APPROVED MEDICAL WASTE MANAGEMENT SERVICE PROVIDER
- → COPY ARCHITECTURAL PLAN APPROVED BY THE LOCAL COUNTY DEVELOPMENT COMMITTEE (FOR NEWLY CONSTRUCTED PREMISES)
- → ATTACH A LIST OF THE EQUIPMENT AVAILABLE IN THE INSTITITION
- → DATA HANDLER/PROCESSOR CERTIFICATE FROM THE OFFICE OF THE DATA PROTECTION COMMISSIONER
- → EVIDENCE OF PAYMENT OF PRESCRIBED FEE

B. VERIFICATION OF THE APPLICATION FORM AND ACCOMPANYING DOCUMENTS

C. INSPECTION BY KMPDC

D. ISSUANCE OF KMPDC HEALTH INSTITUTION REGISTRATION CERTIFICATE

E. ISSUANCE OF KMPDC ANNUAL HEALTH INSTITUTION OPERATING LICENSE

THIS PROCESS TAKES A MAXIMUM OF SIX (6) WEEKS
NOTE: HEALTH INSTITUTIONS SITUATED IN RESTRICTED AREAS SHALL NOT BE CONSIDERED FOR REGISTRATION
A LIST OF RESTRICTED AREAS CAN BE ACCESSED ON OUR WEBSITE
PLEASE COMPLETE THIS FORM IN BLOCK LETTERS

A. HEALTH INSTITUTION DETAILS

CONTACT DETAILS OF THE PROPOSED INSTITUTION

NAME OF THE INSTITUTION	
POSTAL ADDRESS	
OFFICIAL TELEPHONE NUMBER	
MOBILE NUMBER	
E-MAIL ADDRESS	

TYPE OF HEALTH INSTITUTION

DENTAL CLINIC	**DISPENSARY**	**EYE CLINIC**	**MOBILE CLINIC**
BASIC HEALTH CENTRE	**COMPREHENSIVE HEALTH CENTRE**	**FUNERAL HOME STAND ALONE**	**MATERNITY HOME**
NURSING HOME OR COTTAGE HOSPITAL	**INTERNSHIP TRAINING CENTRE**	**PRIMARY CARE HOSPITAL**	**COUNTY HOSPITAL**
COUNTY REFERRAL HOSPITAL	**SPECIALIZED TERTIARY REFERRAL HOSPITAL**	**NATIONAL REFERRAL AND TEACHING HOSPITAL**	**SPECIALIZED HOSPITALS**

CATEGORIZATION AND OWNERSHIP

INSTITUTION OWNERSHIP	**GOVERNMENT OF KENYA**	**COUNTY GOVERNMENT**	**PRIVATELY OWNED**	**FAITH BASED ORGANIZATION**	**NGO**
CATEGORY OF INSTITUTION	**LEVEL 2**	**LEVEL 3**	**LEVEL 4**	**LEVEL 5**	**LEVEL 6**

PHYSICAL LOCATION OF THE HEALTH INSTITUTION

COUNTY	
SUB COUNTY	
CONSTITUENCY	
WARD.	
TOWN/MARKET	
ROAD/STREET	
PROMINENT LANDMARK	
PLOT/LR NUMBER/BUILDING	

LIST OF SERVICES OFFERED

BED CAPACITY

NUMBER OF WARDS	
BEDS PER WARD	

B. DETAILS OF THE APPLICANT

FULL NAME			
IS THE APPLICANT A DIRECTOR AND/OR ADMINISTRATOR OF THE HEALTH INSTITUTION?		**YES**	**NO**
DATE OF BIRTH		PLACE OF BIRTH	
NATIONALITY			
ID/PASSPORT NUMBER			
POSTAL ADDRESS			
MOBILE NUMBER			
E-MAIL ADDRESS			

C. DETAILS OF THE DIRECTOR(S)

ATTACH CERTIFIED COPIES OF DOCUMENTARY EVIDENCE

FULL NAME	
NATIONALITY	
OCCUPATION	
ID/PASSPORT NUMBER	
MOBILE NUMBER	
E-MAIL ADDRESS	
POSTAL ADDRESS	

DETAILS OF THE OTHER DIRECTOR	
FULL NAME	
NATIONALITY	
OCCUPATION	
ID/PASSPORT NUMBER	
MOBILE NUMBER	
E-MAIL ADDRESS	
POSTAL ADDRESS	
DETAILS OF THE OTHER DIRECTOR	
FULL NAME	
NATIONALITY	
OCCUPATION	
ID/PASSPORT NUMBER	
MOBILE NUMBER	
E-MAIL ADDRESS	
POSTAL ADDRESS	
DETAILS OF THE OTHER DIRECTOR	
FULL NAME	
NATIONALITY	
OCCUPATION	
ID/PASSPORT NUMBER	
MOBILE NUMBER	
E-MAIL ADDRESS	
POSTAL ADDRESS	
USE EXTRA SPACE IF NECESSARY	

D. HEALTHCARE PERSONNEL INFORMATION

HEALTHCARE PERSONNEL WHO SHALL BE IN-CHARGE OF THE CLINICAL SERVICES

THE PERSONNEL IN-CHARGE MUST:

→ HAVE ATTAINED 3 YEARS OF EXPERIENCE POST REGISTRATION

→ NOT BE IN CHARGE OF ANOTHER HEATH FACILITY

FULL NAME	
REGISTRATION NUMBER	
YEAR OF REGISTRATION	
REGULATORY BODY	
CURRENT PRACTISE LICENSE NUMBER	
MOBILE NUMBER	
E-MAIL ADDRESS	

DETAILS OF PROFESSIONAL QUALIFICATIONS OF THE PERSON NAMED ABOVE

INCLUDE YEAR AND PLACE WHERE OBTAINED

LEVEL OF EDUCATION	TRAINING INSTITUTION	ACQUIRED QUALIFICATIONS	DURATION OF TRAINING
CERTIFICATE			
DIPLOMA			
UNDERGRADUATE			
POSTGRADUATE			

STATE WORK EXPERIENCE OF THE PERSON NAMED ABOVE

ATTACH CURRICULUM VITAE

CONSENT FOR USE OF PROFESSIONAL QUALIFICATION

I	PROF.	DR.	MR.	MRS.	MISS	WRITE FULL NAME

AS THE OFFICER IN CHARGE OF CLINICAL SERVICES DO HEREBY CONSENT TO THE USE OF MY PROFESSIONAL AND ACADEMIC QUALIFICATIONS

SIGNATURE		DATE	DD	MM	YYYY

HEALTH CARE PROFESSIONALS WHOSE CERTIFICATES HAVE BEEN USED TO REGISTER THE FACILITY ARE REQUIRED TO SEND CONSENT ACKNOWLEDGEMENTS DIRECTLY TO THE FOLLOWING EMAIL ADDRESS: **INFO@KMPDC.GO.KE**

GIVE FULL NAMES AND PROFESSIONAL QUALIFICATIONS OF ANY OTHER PERSON(S), IDENTIFIED BY YOUR INSTITUTION TO UNDERTAKE PATIENT HEALTH CARE AT THE INSTITUTION (CLINICAL OFFICERS, NURSES, COMMUNITY ORAL HEALTH OFFICERS, LABORATORY TECHNICIANS, X-RAY STAFF, DOCTORS, TECHNICIANS, PHARMACEUTICAL TECHNICIANS, ETC.)

DETAILS OF THE OTHER HEALTHCARE PERSONNEL	
FULL NAME	
PROFESSIONAL QUALIFICATIONS	
ID/PASSPORT NUMBER	
REGISTRATION NUMBER FROM REGULATORY AUTHORITY	
CURRENT PRACTICING LICENCE NUMBER	
MOBILE NUMBER	

DETAILS OF THE OTHER HEALTHCARE PERSONNEL	
FULL NAME	
PROFESSIONAL QUALIFICATIONS	
ID/PASSPORT NUMBER	
REGISTRATION NUMBER FROM REGULATORY AUTHORITY	
CURRENT PRACTICING LICENCE NUMBER	
MOBILE NUMBER	

DETAILS OF THE OTHER HEALTHCARE PERSONNEL	
FULL NAME	
PROFESSIONAL QUALIFICATIONS	
ID/PASSPORT NUMBER	
REGISTRATION NUMBER FROM REGULATORY AUTHORITY	
CURRENT PRACTICING LICENCE NUMBER	
MOBILE NUMBER	

DETAILS OF THE OTHER HEALTHCARE PERSONNEL	
FULL NAME	
PROFESSIONAL QUALIFICATIONS	
ID/PASSPORT NUMBER	
REGISTRATION NUMBER FROM REGULATORY AUTHORITY	
CURRENT PRACTICING LICENCE NUMBER	
MOBILE NUMBER	

DETAILS OF THE OTHER HEALTHCARE PERSONNEL	
FULL NAME	
PROFESSIONAL QUALIFICATIONS	
ID/PASSPORT NUMBER	
REGISTRATION NUMBER FROM REGULATORY AUTHORITY	
CURRENT PRACTICING LICENCE NUMBER	
MOBILE NUMBER	
USE EXTRA SPACE IF NECESSARY	

E. DECLARATION BY APPLICANT

I	PROF.	DR.	MR.	MRS.	MISS	WRITE FULL NAME

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

I FURTHER DECLARE THAT I WILL ABIDE BY ALL LAWS, INCLUDING BUT NOT LIMITED TO THE MEDICAL PRACTITIONERS & DENTISTS ACT (CAP 253), AND IT'S ATTENDING REGULATIONS DURING MY ENGAGEMENT

I UNDERSTAND LEGAL ACTION CAN BE TAKEN IF FOUND FALSE

SIGNATURE		DATE	DD	MM	YYYY

FOR OFFICIAL USE					
PREPARED BY					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY
CHECKED BY					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY
REMARKS					
VERIFIED BY					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY
REMARKS					
RECOMMENDED BY					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY
REMARKS					
APPROVED/NOT APPROVED					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY
REMARKS					