REPUBLIC OF KENYA

KMPDC
Enhancing Quality Healthcare

FORM – XXIV

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REQUEST FOR CHANGE OF PARTICULARS FOR 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. DETAILS OF THE APPLICANT	
NAME	
IDENTITY/PASSPORT NUMBER	
NATIONALITY	
MOBILE NUMBER	
EMAIL ADDRESS	

SUBMIT THE DULY FILLED APPLICATION FORM WITH THE FOLLOWING REQUISITE DOCUMENTS

- → COPY OF ID/PASSPORT AND A CURENT COLOURED PASSPORT SIZE PHOTOGRAPH WHERE THE APPLICANT IS NOT A CURRENT DIRECTOR
- → AN OFFICIAL AUTHORIZATION LETTER FROM THE FACILITY'S DIRECTORS IF THE APPLICANT IS NOT A DIRECTOR

B. INSTITUTION DETAILS				
INSITUTION NAME				
RESGISTRATION NUMBER				
FACILITY OWNERERSHIP	GOK	FBO	PRIVATE	CBO

C. NATURE OF CHANGE (*Tick all that apply*)

CHANGE OF NAME
ATTACH A COPY OF AMENDED CERTIFICATE OF INCORPORATION OR BUSINESS REGISTRATION CERTIFICATE/CERTIFICATE OF CHANGE OF NAME

NEW NAME	

CHANGE OF LOCATION

COUNTY	
SUB COUNTY	
CONSTITUENCY	
WARD	

TOWN/MARKET	
ROAD STREET	
PROMINENT LANDMARK	
PLOT/LR NUMBER/BUILDING	

A REQUEST FOR CHANGE OF PHYSICAL LOCATION MUST BE ACCOMPANIED BY THE FOLLOWING

- → PROOF OF NEW PREMISES OWNERSHIP OR LEASE/AGREEMENT
- → FACILITY LAYOUT/ARCHITECTURAL PLAN
- → SANITATION INSPECTION REPORT FROM THE COUNTY DEPARTMENT OF HEALTH WHICH MUST NOT BE OLDER THAN 6 MONTHS
- → CERTIFICATE OF CHANGE OF PARTICULARS

KMPDC MUST INSPECT THE PROPOSED LOCATION PRIOR TO THE APPROVAL OF ANY APPLICATION FOR CHANGE OF PHYSICAL LOCATION

CHANGE OF CONTACT DETAILS

NEW TELEPHONE NUMBER	
NEW EMAIL ADDRESS	
NEW POSTAL ADDRESS	

CHANGE OF DIRECTORS (*Tick all that apply*)

CHANGE OF CURRENT DIRECTOR PARTICULAR(S)	
ADDITION OF NEW DIRECTOR	
REMOVAL OF CURRENT DIRECTOR	

CHANGE OF CURRENT DIRECTOR(S) PARTICULARS
(*Fill in the following updated details of the director*)

NAME	
NATIONALITY	
ID/PASPPORT NUMBER	
MOBILE NUMBER	
EMAIL ADDRESS	
POSTAL ADDRESS	

ADDITION OF NEW DIRECTOR(S) **(***Fill in the details of the new director(s) as they appear on the CR12/ Business Name***)**	
DIRECTOR 1	
NAME	
NATIONALITY	
ID/PASPPORT NUMBER	
MOBILE NUMBER	
EMAIL ADDRESS	
POSTAL ADDRESS	
DIRECTOR 2	
NAME	
NATIONALITY	
ID/PASPPORT NUMBER	
MOBILE NUMBER	
EMAIL ADDRESS	
POSTAL ADDRESS	
REMOVAL OF CURRENT DIRECTOR(S) **(***Fill in the details of the director(s) being removed as they appear on the CR12/Business Name***)**	
DIRECTOR 1	
NAME	
NATIONALITY	
ID/PASPPORT NUMBER	
MOBILE NUMBER	
EMAIL ADDRESS	
POSTAL ADDRESS	
DIRECTOR 2	
NAME	

NATIONALITY	
ID/PASPPORT NUMBER	
MOBILE NUMBER	
EMAIL ADDRESS	
POSTAL ADDRESS	

- → CERTIFIED COPY OF VALID CR12 ISSUED WITHIN THE LAST 6 MONTHS
- → CERTIFIED COPIES OF DIRECORS'PASSPORTS
- → CURRENT COLOURED PASSPORT SIZE PHOTOGRAPHS OF THE DRIECTORS

CHANGE OF OFFICER IN CHARGE OF CLINICAL SERVICES

(*Fill in the details of the newly appointed Officer in Charge of Clinical Services***)**

FULL NAME	
ID/PASSPORT NUMBER	
PHONE NUMBER	
EMAIL ADDRESS	
CURRENT PRACTICE LICENCE	
PROFESSION	
PROFESSIONAL REGISTRATION NUMBER	
CURRENT PRACTICE LICENCE NUMBER	

DETAILS OF PROFESSIONAL QUALIFICATIONS OF THE PERSON NAMED ABOVE

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

CONSENT FOR USE OF PROFESSIONAL QUALIFICATION

(*To be filled in by the new Officer in Charge of clinical services***)**

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

SUBMIT THE DULY FILLED APPLICATION FORM WITH THE FOLLOWING REQUISITE DOCUMENTS FOR THE NEW OFFICER INCHARGE OF CLINICAL SERVICES

- → CERTIFIED COPIES OF ACADEMIC AND PROFESSIONAL CERTIFICATES
- → CERTIFIED COPY OF REGISTRATION CERTIFCATE AND CURRENT LICENCES FROM RELEVANT REGULATORY BODY
- → CURRENT CERTIFICATE OF STATUS
- → CERTIFIED COPY OF EMPLYMENT CONTRACT/JOB OFFER
- → CURRICULUM VITAE
- → CURRENT COLOURED PASSPORT SIZE PHOTOGRAPH

OTHER CHANGE(S) **(*Please Specify)***	

D. DECLARATION BY APPLICANT

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

THE UNDERSIGNED , HEREBY DECLARE THAT THE INFORMATION PROVIDED IN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY/OUR KNOWLEDGER. I/WE UNDERSTAND THAT ANY FALSE DECLARATION MAY RESULT IN LEGAL ACTION

SIGNATURE		DATE	DD	MM	YYYY

FOR OFFICIAL USE

PREPARED 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 BY					
NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY
REMARKS					