APPLICATION
For
PRE ACCREDITATION ENTRY LEVEL
FOR HOSPITAL

Issue No.: 01
Issue Date: July 2014

NATIONAL ACCREDITATION BOARD FOR HOSPITALS and HEALTHCARE PROVIDERS

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Assessment criteria and Fee structure

Hospital		
Assessment	**Application Fee**	**Certification Fee**
One man day	Rs. 2,000/-	Rs. 25,000/-

NOTE: The man days given above for assessment are indicative and may change depending on the facilities and size of the Hospital.

Service Tax applicable from time to time (currently @ 14.50%) will be charged on all the above fees. You are requested to please include the service tax in the fees accordingly while sending to NABH.

Guidance notes:

1. The Hospital can fill the application form online (www.nabh.co) through the website & submit the documents and fees online. Fees are non-refundable.
2. In case of any difficulty in accessing online system, application form can be download from the web-site. Three hard copies of this application form duly filled in are to be submitted along with self-assessment toolkit, necessary documents and fees. Fees to be paid through Demand Draft in favour of Quality Council of India payable at New Delhi. Fees to be paid through Demand Draft in favour of Quality Council of India payable at New Delhi.
3. The certification fee includes expenses on travel, lodging/ boarding of assessor
4. The applicant hospital must make all payment due to NABH, before the onsite assessment is conducted.
5. The certification, once granted will be valid for two years, after which the hospital may apply for renewal as per NABH policy or hospital may prepare and move to the next stage - “Pre Accreditation Progressive” Level/ “Full Accreditation” status.

Guidelines for filling the application form

(Please read this carefully before filling this form)

1. For offline applications/hard copy, kindly fill the application form in **BLACK INK** only. You can also submit a typed version of the filled application form.
2. **For Sl. No. 3**: Split locations - This pertains to all units which are a part of the hospital. e.g. outreach clinics, satellite clinics, laundry, etc.
3. **For Sl. No. 5**: Please specify e.g. Clinical Establishment Act, Shops and Establishments Registration Act etc.
4. **For Sl. No. 8**: Please state the number currently in operation. For example, the hospital may have approval for 250 beds but presently if only 100 beds are operational, please mention only 100 (after exclusions mentioned against that point). *However, the hospital shall inform NABH of any increase in operational beds within 15 days of making the additional operational beds.*
5. **For Sl. No. 8.d:** Provide the information using the example below.

Address (Location)	Building / Block	Level	Area/Activity
		Ground floor	OPD, Billing, Reception, Laboratory
		First floor	OT, ICU

6. **For Sl. No. 12,13,14, and 15**:
   a. Please indicate “Yes” only if there are individuals holding recognised degrees managing the department. Please ensure that there are OP services for all the ticked specialities (excluding lab). However, you can include a department not having OP but providing all other care.
   b. Under the column number of consultants mention only consultants (and not resident doctors or fee for service doctors who visit the hospital only when called).Please mention full time and part time consultants separately as X + Y=Z
   c. While filling the row “others” mention only the name of any recognised speciality. Please do not mention services e.g. laparoscopic surgery as departments.
   d. Please note that this list of specialities is based on the recognised medical courses by the Medical Council of India/ National Board of Examination.
   e. **PLEASE NOTE THAT THE SCOPE OF CERTIFICATION SHALL BE TRANSCRIBED FROM THESE FOUR HEADINGS ONLY.** For the sake of uniformity the scope shall mention the specialities using the same terminology.
7. **For Sl. No. 17**: Type of care pertains to nature of service e.g. adult/paediatric; male/female. Use codes like AM (adult male), AF (adult female), AMF (adult male and female), PM (paediatric male), PF (paediatric female), PMF (paediatric male and female). If there is no categorization please mention as open to all. In case of split locations please specify the location
8. **For Sl. No. 19**: Kindly provide a copy of authorization/permission from the respective agency.
9. The hospital shall ensure that it shall send an updated application form to NABH in case of any changes especially before on site assessment.

DEMOGRAPHIC AND GENERAL DETAILS:

1. **Applying for (please tick the relevant)**

   a. **Certification** ☐

   b. **Renewal** ☐
   Renewal cycle number ……

2. **Name of the Hospital:** (the same shall appear on the certificate)

   _____

3. **Contact Details of Hospital:**

   Street Address _____

   City/Town _____

   Locality/Village/Tehsil _____

   District _____

   State _____

   Website: _____

   Location of Hospital: **Urban** ☐ **Rural** ☐

   Does the hospital have split location(s): Yes ☐ No ☐
   If yes, address of the other location(s) and distance from main location

   _____

   _____

   _____

4. **Ownership:**

   ☐Private – Corporate ☐Armed Forces

   ☐PSU ☐Trust

   ☐Government ☐Charitable

   ☐Others (Specifiy.....)

5. **Year and month in which registered and under which authority (as per state and central requirements)**

   _____

6. **Year and month in which clinical functions started:**

   _____

7. Contact person(s):
(Please indicate [√] with whom correspondence to be made)

- Top Management in the Hospital

  Mr. /Ms. /Dr. _____

  Designation: _____

  Tel: _____ Mobile: _____

  Fax: _____ E-mail: _____

- **Pre Accreditation Coordinator:**

  Mr./Ms./Dr. _____

  Designation: _____

  Tel: _____ Mobile: _____

  Fax: _____ E-mail: _____

8. Hospital Information:

a. Total Number of Beds that have been sanctioned: ……..

b. **Total Number of Beds currently in operation:** ……(please exclude emergency, day-care, dialysis, recovery room beds, labour room beds from this number)

Bed Type	Number of Beds
In patient beds (non ICU)	
In patient beds (ICU)	
Total	

Others:	
• Emergency beds	
• Day-care beds	
• Recovery room beds	
• Labour room beds	
• Dialysis	
• (Specify)	
• (Specify)	

c. Number of OTs:

General: _____ **Super-speciality:** _____

d. Hospital layout:

i. Number of buildings _____

ii. List the areas / departments / units floor wise for each building in a tabular format as mentioned in point 5 in the guidelines and provide it as an attachment.

iii. In case of split location the layout for each of the addresses must be given.

.CLINICAL SERVICES AND RELATED DETAILS

9. OPD and IPD data:

a. OPD DATA (Past 2 years)

Year	Number of Patients

b. IPD DATA (Past 2 years) OR AVERAGE OCCUPANCY RATE

Year	Number of Patients Admitted

10. Ten most frequent clinical diagnosis for in patients:

i. …… vi. ……
ii. …… vii. ……
iii. …… viii. ……
iv. …… ix. ……
v. …… x. ……

11. Ten most frequent surgical procedures done for in patients

i. …… vi. ……
ii. …… vii. ……
iii. …… viii. ……
iv. …… ix. ……
v. …… x. ……

12. Scope of Certification - Broad Specialities in the hospital:

Speciality	Service Provided *(mention YES or NO)*	Average daily of Out patients during the Previous Calendar Year	Average daily In Patients during the Previous Calendar Year	Number of Consultants
Anaesthesiology				
Dermatology and Venereology				
Emergency Medicine				

Family Medicine				
General Medicine				
Geriatrics				
General Surgery				
Obstetrics and Gynaecology				
Ophthalmology				
Orthopaedic Surgery*				
Otorhinolaryngology				
Paediatrics				
Psychiatry				
Respiratory Medicine				
Sports Medicine				
Day Care Services				
➢				
➢				
➢				
➢				
Others, please state	**YES/NO**			
Among the above please list the services which are outsourced if any:				
**Please mention if joint replacement or arthroscopic procedures are being done:*				

13. Scope of Certification - Super Specialities in the hospital:

Speciality	Service Provided (mention Yes/ No)	average daily of Out patients during the Previous Calendar Year	Average daily In Patients during the Previous Calendar Year	Number of Consultants
Cardiac Anaesthesia				
Cardiology				
Cardiothoracic Surgery				
Clinical Haematology				
Critical Care				
• **Combined**		NA		
• **Speciality ICU (please specify)**				
•		NA		
•		NA		
•		NA		
•		NA		
•		NA		
•		NA		
•		NA		
•		NA		
Endocrinology				
Hepatology				
Hepato-Pancreato-Biliary Surgery				
Immunology				
Medical Gastroenterology				
Neonatology				
Nephrology				
Neurology				
Neuro-Radiology				

Neurosurgery				
Nuclear Medicine				
Oncology				
➢ **Medical Oncology**				
➢ **Radiation Oncology**				
➢ **Surgical Oncology**				
Paediatric Gastroenterology				
Paediatric Cardiology				
Paediatric Surgery				
Plastic and Reconstructive Surgery				
Rheumatology				
Surgical Gastroenterology				
Urology				
Vascular Surgery				
Transplantation Service				
➢				
➢				
➢				
➢				
Others, please state				
Among the above please list the services which are outsourced if any:				

14. **Scope of Certification - Clinical Support departments/services in the hospital (mention Yes/ No):**

	In House	Out sourced
Ambulance		
Blood Bank / transfusion services		
Dietetics		
Psychology		
Rehabilitation		
➢ Occupational Therapy		
➢ Physiotherapy		
➢ Speech and Language Therapy		

15. **Scope of Certification - Diagnostic Services in the hospital (mention Yes/ No):**

Diagnostic Service	In House	Out sourced
Diagnostic Imaging:		
Bone Densitometry		
CT Scanning		
DSA Lab		
Gamma Camera		
Mammography		
MRI		
PET		
Ultrasound		
X-Ray		
Laboratory Services:		
Clinical Bio-chemistry		
Clinical Microbiology and Serology		
Clinical Pathology		
Cytopathology		
Genetics		
Haematology		

Histopathology		
Molecular Biology		
Toxicology		
Other Diagnostic Services:		
2D Echo		
Audiometry		
EEG		
EMG/EP		
Holter Monitoring		
Spirometry		
Tread Mill Testing		
Urodynamic Studies		
Any Other Diagnostic Service (s):		

16. Details of Non Clinical and Administrative departments (mention Yes/ No):

Support Service	In House	Out sourced
Bio-medical Engineering		
Catering and Kitchen services		
CSSD		
General Administration		
Housekeeping		
Human Resources		

Information Technology		
Laundry		
Maintenance/Facility Management		
Management of Bio-medical Waste		
Mortuary Services		
Pharmacy		
Security		
Community Service		
Supply Chain Management/ Material Management		
Other, please specify		

17. List Ambulatory unit / Inpatient Care Units/ Wards, the Number and The type of care given in each Unit/ Ward: *Refer paragraph 7 page 3*

Name of Unit/ Ward	Number of Beds	Type of Care

18. A. Staff Information*:

Group	Number	Remarks if any
Managerial		
Doctors		
➢ **Resident (non PG) / Medical Officer**		
➢ **Consultants**		
a) Full Time		
b) Part Time		
Allied Medical Speciality Staff*		
Nurses		
Technicians		
Housekeeping staff		
Others		

18. **B. Student Information*:**

Student Group: UG / Intern / PG *(Medical, Nursing, Others- specify)*	**Number**	**Remarks if any**

19. **Other Information :**

Name	**Issuing Authority**	**Number and Date of issue**	**Valid Upto**	**Remarks**
Bio-medical Waste Management and Handling Authorization				
Registration Under Clinical Establishment Act (or similar)				
Registration With Local Authorities, if applicable				
Registration for Modality				
License to operate(CT/IR)				
Blood bank/ Storage centre				
License for MTP				
Registration for PNDT				
Others				

20. **Litigation, if any:**

_____

21. **Date of last Self-assessment:** _____

22. Date of implementation of NABH Pre Accreditation Entry Level Standards:

_____

(Hospital shall apply at least 3 months after implementing NABH Pre Accreditation Entry Level Standards)

23. I have gone through the contents of the "NABH Pre Accreditation Entry Level Certification Agreement" and have fully understood the various clauses and shall abide by the same.

24. Date Application Completed: _____Day _____Month _____Year

_____

Authorised Signatory (CEO or equivalent)

Name: _____

Designation: _____