Form .....IX.....

ORIGINAL

rule 4(1)

Serial No.....

REPUBLIC OF KENYA

THE MEDICAL PRACTITIONERS AND DENTISTS ACT

(Cap. 253)

APPLICATION FOR REGISTRATION OF A MEDICAL INSTITUTION

PART 1

To be completed by the applicant in duplicate

1. CONTACT DETAILS OF THE PROPOSED INSTITUTION

(Block Letters)

a) NAME OF THE MEDICAL INSTITUTION.....……

b) POSTAL ADDRESS…….……...

c) TELEPHONE NUMBER……MOBILE…….……..……

d) EMAIL ADDRESS..... .....

2. ALL TYPE (Dental Clinic , Dispensary ,Faith Based, Dispensary , Mobile Clinic , Eye Clinic , Faith Based Basic Health Centre , Basic Health Centre , Faith Based Comprehensive Health Centre , Comprehensive Health , Medical/Dental Centre , Funeral Home Stand Alone , Maternity Home , Nursing Home/Cottage Hospital , Faith Based Level 4 Hospital , Hospital Level 4/ Internship Training Centre/County Hospital , Faith Based Hospital Level 5 , Hospital Level 5/ County Referral Hospitals , Faith Based Specialized Tertiary Referral Hospital , Specialized Tertiary Referral Hospital , Faith Based National Referral and Teaching Hospitals and specialized hospitals Level 6 , National Referral and Teaching Hospitals and specialized hospitals Level 6).

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3. LOCATION OF THE MEDICAL INSTITUTION

a) Town/Centre/Market.....

.....

b) Location..... .....

c) County.....

PART II

(To be completed by the applicant in duplicate)

1. FULL NAMES AND ADDRESS OF THE APPLICANT

(Block Letters)

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....

2. STATE IF APPLICANT IS A DIRECTOR AND/OR ADMINISTRATOR OF THE MEDICAL INSTITUTION

.....

** Delete where inapplicable*

3. NATIONALITY OF THE APPLICANT

.....

4. PLACE AND DATE OF BIRTH.....

.....

5. KENYA NATIONAL IDENTITY CARD No.

.....

(Attach Photocopy)

6. PASSPORT No. (*if applicable*)……

7. EMAIL ADDRESS.....

8. WORK PERMIT No. (if applicable)

.....

(Attach documentary evidence- copies only).

PART III

(To be completed by the applicant in duplicate)

Give full names of Directors of the institution including the following: Nationalities, Passport Numbers, Work Permit Numbers, Email Address, Kenya National Identity Card Numbers, etc

(Attach copies of documentary evidence).

i) ……

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ii) ……

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iii) ……

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(Use extra space if necessary).

PART IV

(To be completed by the applicant in duplicate)

1. Give full names and registration number of the medical or dental practitioner who shall be in-charge of the patient health care at the proposed institution:

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2. a) Give full details of professional qualifications of the person named at paragraph (1) of PART IV above. Include year and place where obtained.

   b) State work experience of the person named at paragraph (1) of PART IV above and name institutions where obtained and date.

   c) Attach documentary evidence (photocopies) in each case. (Please use extra space if necessary).

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3. (a) Give full names and professional qualifications of any other person(s), identified by your institution to undertake patient health care at the institution(e.g., Clinical Officers, Nurses, Laboratory Technicians, X-ray Staff, Doctors, Technicians, Pharmaceutical Technicians, etc.).

   (b) Attach documentary evidence (photocopies) in each case. (Please use extra space if necessary).

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   (ii) ……

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   (iii)……

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PART V

(To be completed by Medical Officer of Health in duplicate)

INSPECTION REPORT FOR MEDICAL INSTITUTIONS- FOR REGISTRATION PURPOSES

1. **NAME OF THE INSTITUTION**……

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2. PHYSICAL LOCATION

(a) Plot No./L.R. No…….....

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(b) Market/Centre/Town*……

(c) Street / Road..... .....

(d) Location..... .....

(e) County.....

3. PREMISES GENERAL INFORMARION

(a) Plot area (in hectares)..... .....

(b) Water supply.....adequate/inadequate*

(c) Refuse disposal

(i) Incinerator available/Not available.*

(ii) Other modes of refuse disposal

(Specify)

.....

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(d) Environmental suitability .....recommended/ not recommended.* State reasons for not recommending:

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4. PLAN OF THE INSTITUTION

*(a)*Approved/ No approved* by the local District Development Committee (attach copy of the plan) and documentary evidence (copies) of approval of the institution by the D.D.C

5. OUT -PATIENT SERVICES

(See attached minimum requirements for General Practice).

*(a) Waiting Bay/ Reception Area/Room: **

(i) Seating capacity.....

(ii) Area (in square meters).....

(iii) Construction .....Covered/ Not Covered. *

** Delete where inapplicable.*

(b) Examination Rooms:

(i) Number of rooms.....

(ii) State if equipment inspected meets the minimum requirements. Attach separate signed list of equipment inspected if necessary.

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(c) Treatment room:

(i) Number of rooms.....

(ii) State if equipment meets the minimum requirements. Attach separate signed list of equipment inspected.

6. IN-PATIENT SERVICES

(a) Female Ward:

(i) Size of the ward (in square metres).....

(ii) Number of beds.....

(iii) Number of toilets.....

(iv) Number of bathrooms.....

(v) Number of sluice rooms.....

(b) Male Ward:

(i) Size of the ward (in square metres).....

(ii) Number of beds.....

(iii) Number of toilets.....

(iv) Number of bathrooms.....

(v) Number of sluice rooms.....

(c) Maternity Ward:

(i) Size of the ward (in square metres).....

(ii) Number of beds.....

(iii) Number of toilets.....

(iv) Number of bathrooms.....

(v) Number of sluice rooms.....

(vi) Placenta pit depth (in meters).....

(d) Paediatric Ward:

(i) Size of the ward (in square metres).....

(ii) Number of beds.....

(iii) Number of toilets.....

(iv) Number of bathrooms.....

(v) Number of sluice rooms.....

7. CLINICAL SUPPORT SERVICES

(a) Pharmacy:

(i) Area of the waiting room (in square metres).....

(ii) Number of dispensing windows.....

(iii) Number of antibiotic (safe cupboards.....

(iv) Number of drug stores.....

(b) Laboratory:

(see attached minimum requirements)

(i) Reception area (in square metres).....

(ii) Seating capacity.....

(iii) Size of work-room (in square metres).....

(iv) Equipment (attach a separate signed list of equipment and reagents/chemicals inspected).

(c) X- ray Unit:

(See attached minimum requirements).

(i) Size of the reception area (in square metres).....
(ii) Seating capacity.....
(iii) Number screening rooms.....
(iv) Standard of radiation protection.....
Adequate/Not Adequate. *
(v) Equipment (attach separate signed list of equipment inspected).

(d) Operating Theatre:

(i) Minor theatre equipment (attach separate signed list of equipment inspected).
(ii) Major theatre (indicate by a tick or cross in the box next to the item to show whether available or not).
Induction room..... ☐
Operating room..... ☐
Recovery room..... ☐

Lighting..... (Adequate/Not Adequate).*
Equipment..... (attach separate signed list of equipment inspected).

8. OTHER SUPPORTING SERVICES

(a) *Kitchen*

(i) Cooking facility
(specify).....
(ii) Non-Perishable store..... (Adequate/Not Adequate).*
(iii) Perishable store..... (Adequate/Not Adequate).*

(b) *Laundry Type (specify).....*
.....

(c) *Mortuary:*

(i) Available/ Not Available.*

(ii) Refrigerated/ Not refrigerated.*

(iii) Appropriately located /Not appropriately located.*

If not appropriately located, state why.....

.....

(iv) Body capacity.....

(v) Adequate Privacy /Not Adequate Privacy.*

(vi) Number of ambulances.....

(vii) Other facility (specify and use extra space if necessary .....

** Delete where inapplicable*

PART VI

(To be completed by the Medical Officer of Health in duplicate)

1. Give full names and designations of members of the D.H.M.T who participated in the inspection of the institution.

NAME	DESIGNATION
(i)	
(ii)	
(iii)	
(iv)	
(v)	
(vi)	
(vii)	
(viii)	
(ix)	
(x)	

2. **CERTIFICATE BY M.O.H**

I, Dr.....
.....

(State full names in Block Letters)

being the Medical Officer of Health in-.....District, do hereby certify that the inspection of ..... was conducted by the District Health Management Team of ..... on .....day of.....20…….....under my personal supervision.

I further certify that the inspection was witnessed by Dr./Mr./Mrs./Miss……..…….
..... being the Owner/Director/Applicant * and that.....
the said institution does/does not* meet the minimum requirements for Registration /Licensing purposes.

Dated this .....day of .....,20.....

Signature.....

(Medical Officer of Health)

Name of Station.....

Address.....

Telephone Number.....

** Delete where inapplicable*

PART VII

(To be completed by the Applicant/ Director/ Owner of the institution in duplicate)

I, Dr. /Mr. /Mrs. /Miss *.....

(Full Names in Block Letters)

hereby certify that all the information given by me in the application form is true and correct and that I personally witnessed the inspection which was conducted by the Medical Officer of Health on

.....day of ....., 20.....

Signature.....

Name in Full.....

APPLICANT TO NOTE:

This form **MUST** be returned to the Medical Practitioners and Dentists Board within a period not exceeding three months from the date of issue. Applications which are not returned within the stipulated period shall be time barred.

PART VIII

(For the purposes of vetting applications and enforcement of Laws, Regulations and Decisions of the I.R.C. and the Board.)

(a) Name of the institution acceptable to the I.R.C.....

(b) Type of institution.....

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(c) Give Name, Type, Locations and Registration Numbers of other institutions operated by the Applicant/ Director or affiliated to the institution named in this application:

(iv)……

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(v) ……

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(vi)……

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(vii) ……

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(Use extra space if necessary).

** Delete where inapplicable*

(d) Give full particulars of criminal court proceedings for violations of any of the following Ministry of Health laws by any of the institution named in paragraph *"c"* of PART VIII in this application:

Cap. 253, Cap. 260, Cap. 257, Cap 244, Cap 245, Cap. 254 and Cap. 242 (Quote court case references in each case for the past three years proceeding the date of this application

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(use extra space if necessary).

e) Give names of institutions, their location and registration numbers from among those named at paragraph *"c"* PART VIII in this application which have defaulted in licence fees payment during the past three years. State each year of default and penalty imposed and whether or not / penalty has been paid and fees recovered:

(i) ……
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(ii) ……
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(use extra space if necessary).

(f). Give names of any of the institutions named at paragraph "c" of PART VIII in this application which the Board has authorized closure during the past three years (quote minutes references of the I.R.C. and state the institutions' registration number and place of location).

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(Use extra space if necessary).

(g) F.R.L. Serial No. and date of this application.....

(h) Licence Fees Category (quote I.R.C. minutes reference).....

(i) F.R.L. Receipt No. and Date.....

(j) Date application returned to applicant.....

(k) Date application re-submitted by applicant.....

(l) Registration Fees Receipt No. and Date.....

CERTIFICATE BY AN OFFICER AUTHORIZED FOR THE PURPOSES OF PART VIII OF THIS APPLICATION
(This certificate must be countersigned by the Registrar)

I certify that the institution for which this application is made a its Owner/Director/Applicant or its Administrator has/has not been * subject to the criminal proceedings in violation of any of the laws named in PART VIII *"d"* in this application and that all information given under PART VIII of this application is correct and true.

Dated this.....day of ....., 20.....

....
Authorized Officer *Registrar, M.P. and D.B*

PART IX

FOR OFFICIAL USE ONLY

1. INSTITUTION	REGISTRATION	COMMITTEES	RECOMMENDATIONS
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Dated this.....day of....., 20.....

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Chairman Chairman, Committee
Medical Practitioners and Dentists Board

** Delete where inapplicable*

INSTRUCTIONS TO THE REGISTRAR BY THE BOARD

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Dated this.....day of .....,20……...

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Chairman

Medical Practitioners and Dentists Board

GPK